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JANUARY, 1900

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THE MEMPHIS LANCET

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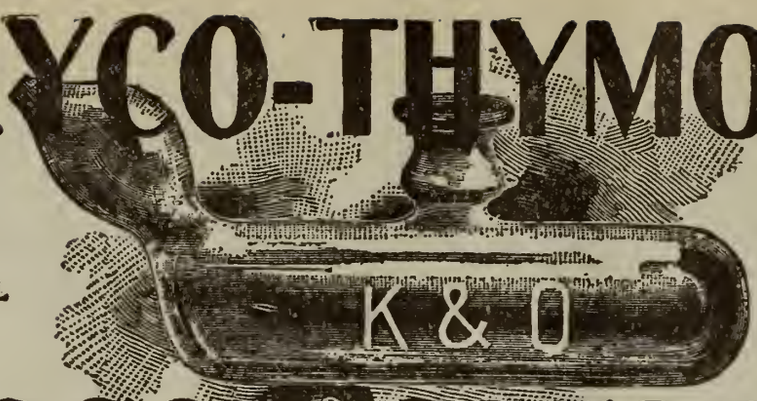

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The February LANCET will contain articles on "The Complications of Typhoid Fever," by Dr. A. E. Cox, of Milan, Tenn.; "Some Obstinate Forms of Neuralgia," by Dr. Henry Posert, of Memphis; "The Management of the Insane," by Dr. N. F. Raines, of Memphis; and others.

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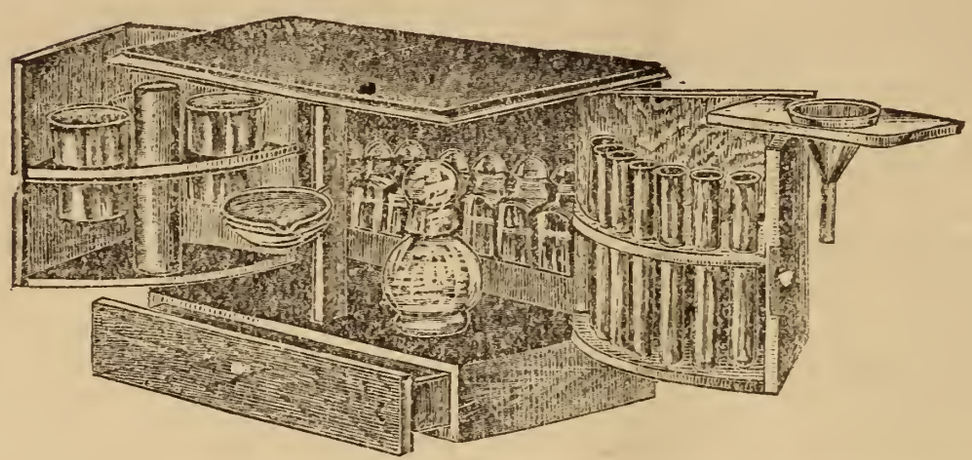

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The March LANCET will contain an article on Pseudo-Cyesis, by Dr. Alfred Moore; one on Elephantiasis of the Scrotum, by Dr. G. G. Buford; a Case Report by Dr. R. B. Maury, and other original articles, besides the Society Proceedings, and an especially good assortment of abstracts.

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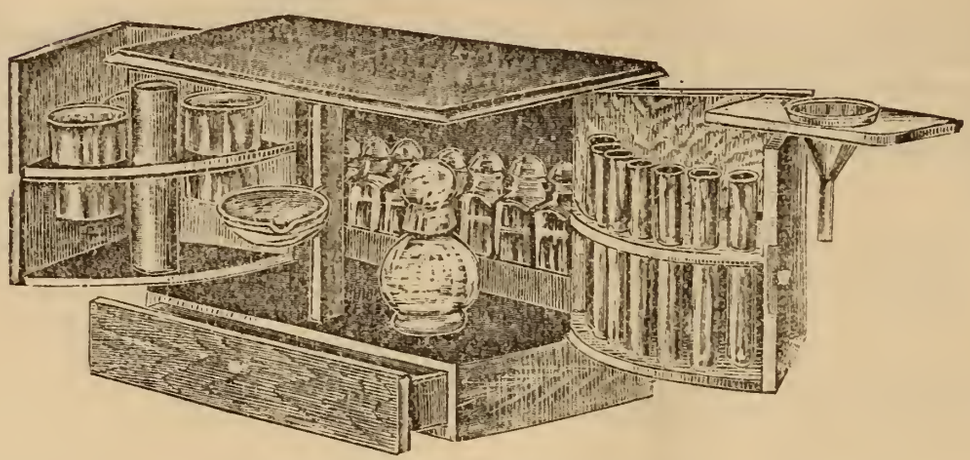

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The April LANCET will contain "A Report of a Case of Extra-Uterine Pregnancy," by Dr. R. B. Maury; a paper on "Abscess of the Liver," by Dr. M. Goltman; "Why I Use Pepto-Mangan (Gude)," by Dr. Wm. Krauss; and "Typhoid Fever in Infancy and Childhood," by Dr. E. D. Mitchell.

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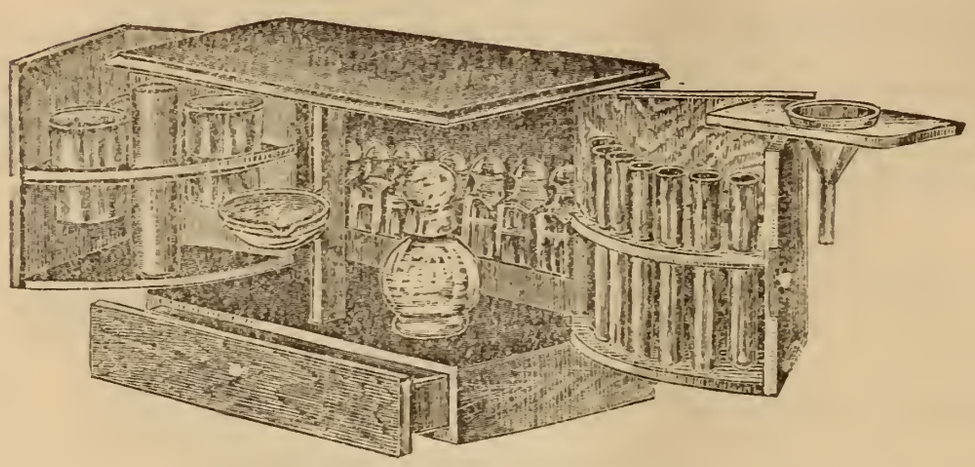

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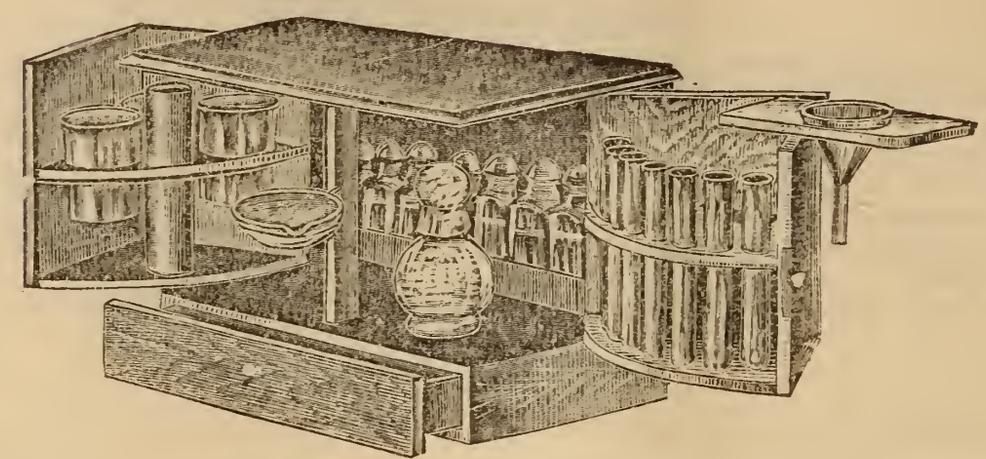

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MEMPHIS LANCET.

VOLUME IV. JANUARY, 1900. No. 1

ORIGINAL ARTICLES.

REPORT OF FOUR MONTHS' SERVICE IN INTERNAL MEDICINE AT ST. JOSEPH'S HOSPITAL, MEMPHIS.*

BY WM. KRAUSS, M.D.

Pathologist, and one of the Visiting Physicians.

This service extended from July 1 to November 1, of this year. The beds actually at my disposal were 22, but there was a potential capacity of 32 beds by encroaching upon the surgical ward and some private rooms when not otherwise occupied. These beds were always full and many patients had to be turned away owing to lack of room. This being the case, experimental work could not be undertaken, as it was imperative to work rapidly so as to give as many patients a chance to get treatment as possible.

Sixteen patients were received from the preceding staff member, Dr. S. E. Rice, while 22 remained at the close of my service; all of these are included in my table, which foots up to 354 patients, which with an average daily residence of 27, would make the average term of each patient 9⅔ days. One patient remained nine weeks, many remained several weeks, and by actual count the majority of the malarial cases remained five days, double tertian seven, post-malarial four, and estivo-autumnal ten days, the longest being six weeks.

There were no female patients or children in this service.

*Read before Tri-State Med. Assn. of Miss., Ark. and Tenn., Memphis, Nov. 14, 1899

The following is the list of diseases and number of cases:

DISEASE	No. Cases	Cured	Improved	Died	Remaining
Acetanilid poisoning, chronic	1	1	.....	.....	.....
Alcoholism, acute	1	1	.....	.....	.....
Aneurism, subclavian	1	.....	1	.....	.....
Anemia	1	1	.....	.....	.....
Bronchitis	3	3	.....	.....	.....
Carbuncle	2	2	.....	.....	.....
Cardiac asthenia	1	1	.....	.....	.....
disease, valvular	2	.....	2	.....	.....
Cirrhosis, liver	1	.....	1	.....	.....
Constipation	2	2	.....	.....	.....
Cystitis, acute	2	2	.....	.....	.....
Diarrhea, acute and chronic	10	9	.....	.....	1
Dysentery, acute and chronic	12	5	3	2	2
Disseminated insular sclerosis	1	.....	1	.....	.....
Encephalitis, alcoholic	1	.....	.....	1	.....
Fever, malarial	239	221	7	1	10
thermic	5	5	.....	.....	.....
typhoid	4	2	.....	.....	2
Gastritis, acute	2	2	.....	.....	.....
chronic	3	3	.....	.....	.....
Herpes cruralis	1	1	.....	.....	.....
Heat prostration	2	2	.....	.....	.....
Hematuria, renal	1	1	.....	.....	.....
Hemorrhage, intestinal, non-febrile	1	.....	.....	1	.....
Hepatitis, chronic	1	.....	1	.....	.....
Indigestion, acute	2	2	.....	.....	.....
Insolation	2	1	.....	.....	1
Lead poisoning, chronic	2	1	.....	.....	1
Meningitis, acute febrile	1	.....	.....	1	.....
chronic, spinal	1	.....	1	.....	.....
Morphin habit	4	.....	3	1	.....
and cocain	1	.....	1	.....	.....
Neuritis, multiple	1	.....	1	.....	.....
Nephritis, chronic	3	.....	.....	1	2
Pneumonia, chronic	2	.....	.....	.....	2
Ptyalism	3	3	.....	.....	.....
Rheumatism, acute articular	4	3	.....	.....	1
chronic	3	2	.....	.....	1
muscular	5	5	.....	.....	.....
syphilitic	3	3	.....	.....	.....
sciatic	2	2	.....	.....	.....
lumbago	1	1	.....	.....	.....
Syphilis, secondary	1	1	.....	.....	.....
Tabes dorsalis	1	.....	1	.....	.....
Tuberculosis, pulmonary	9	.....	6	2	1
intestinal	1	.....	.....	1	.....
kidneys and bladder	1	.....	.....	1	.....
Ulcer, laryngeal (glanders)	1	.....	1	.....	.....
Total	354	288	30	12	24

The malarial cases classify as follows:

Unclassified	31	Estivo-autumnal	29
Intermittent	24	Hematuric	5
Tertian	51	Chronic	5
double	31	Splenitic	14
Quartan	5	Post-malarial malaise	40
triple	1		
Acute pernicious	3	Total	239

The twelve deaths make a ratio to all cases treated of 3.38 per cent. Recapitulating these, we have:

Dysentery, chronic	2	Morphin habit	1
Encephalitis, alcoholic	1	Nephritis, chronic	1
Fever, malarial (hematuric)	1	Tuberculosis, pulmonary	2
Hemorrhage, intestinal	1	intestinal	1
Meningitis, acute febrile	1	renal and cystic	1

The two fatal cases of dysentery were past middle life, with multiple ulcers. The case of alcoholic encephalitis was admitted in a comatose condition and died in 48 hours, failing to rally under energetic treatment. The one death from malaria of the 239 cases was a hematuric whom I had seen only once before he died; death took place in the congestive stage; an effort to get an autopsy proved futile.

The next death baffled me considerably; he was in the hospital about two days, and all efforts to stop the hematemesis and bloody stools failed; he was too ill to give an account of himself, and, after spending two hours over his autopsy, the only thing I could find was exsanguinated tissues; there was no aneurism, and no ruptured vessel could be found.

The case of meningitis was in the hospital six weeks and was fairly convalescent, when he suddenly failed, and all efforts on the part of the house physician to resuscitate him proved ineffectual; the autopsy showed complete absorption of the exudate in the cranial cavity, but the cord was surrounded with fluid throughout its extent; I believe lumbar puncture would have saved this man, but he was doing so well that such an interference did not appear warranted.

The next death, morphin habit, should have been entered as advanced sclerosis; he was an old man who had taken morphin many years, and no attempt to treat the morphinism was attempted; he died comatose.

The next four simply came to the hospital to die, but the last one was of considerable interest, and with your indulgence I will report it briefly:

Case 909. Admitted July 6, 1899; was sick four months with pain in pelvis and lower extremities, with great weakness. Had frequent painful micturition, as often as every half hour; temperature on admission 101°F., fluctuating until it reached normal; after a few days he developed a dysenteric trouble and was referred to the proctologist, Dr. Henning, who found no ulcer. On the 28th he was returned to my department. He had passed very little urine during the last 36 hours; diuretics increased it slightly, but a purulent discharge now came from the penis, the diarrhea became irregular in character and course, the pelvic pains were constant, patient was very apathetic and did not answer questions directly; there having been no urine saved, I requested the house physician to draw some for examination with a catheter, but none could be obtained. No more urine was voided but there was no uremia, whilst on the other hand, peritonitis supervened, from which he died August 3, 1899.

Considering that only a purulent, urinous-smelling fluid escaped for several days before death without symptoms of uremia, the case puzzled me considerably, and I was very much gratified to get an autopsy, from the notes of which I cull the following:

Lungs, liver and heart, pale but normal; omentum engorged; glands of pelvic peritoneum and mesentery enlarged and hard; cheesy centers were found in some. The bladder walls were thickened and contracted and there were four large ulcers, one of which had perforated, filling the pelvis with the purulent urinous fluid. This accounted for the anuria. The position of the ulcer precludes the possibility of the bladder having been perforated by the catheter. (Specimen passed for examination.)

The kidneys both showed subcapsular multiple abscesses and miliary tubercles; there was some interstitial nephritis; the pelves of the kidneys were nearly obliterated.

Two ulcers were found high up in the rectum with some stricture in consequence.

Anatomic diagnosis: Tuberculosis of the pelvis, bladder and kidneys.

I would like the indulgence of the Association until I sketch over a few of the fever cases. It will be noted that among all the 354 cases occurring during the season of greatest prevalence of

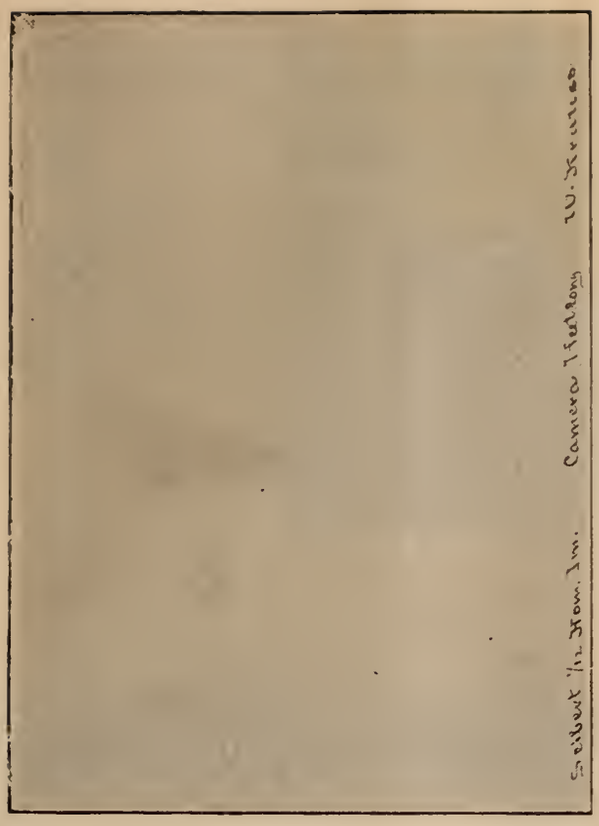


PLATE I.

PLATE II.

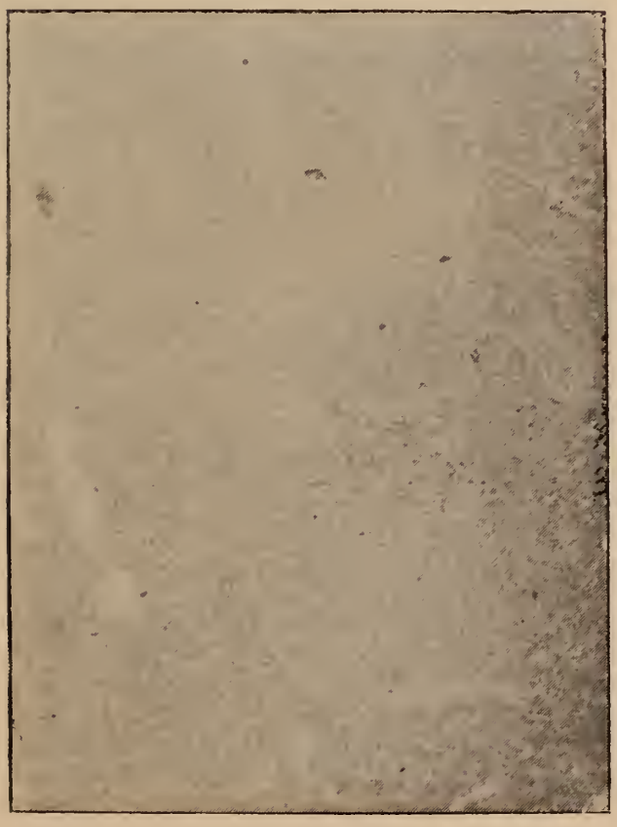


PLATE III.

PLATE IV.

PLATE V.

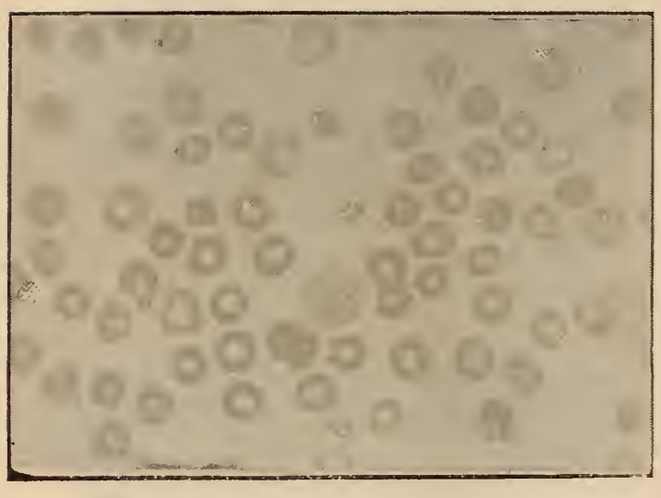


PLATE VI.

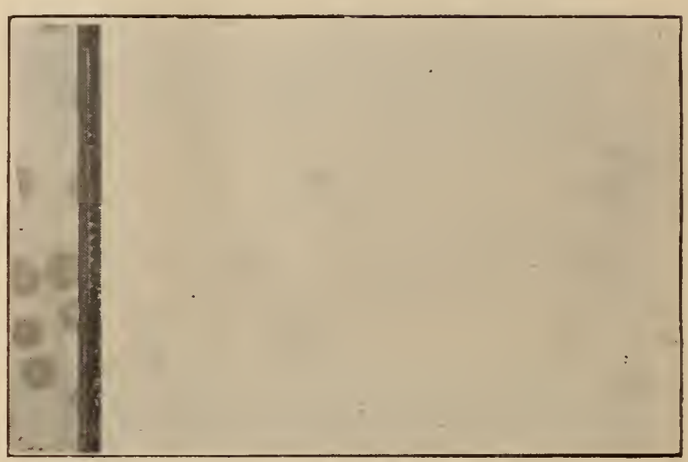


PLATE VII.

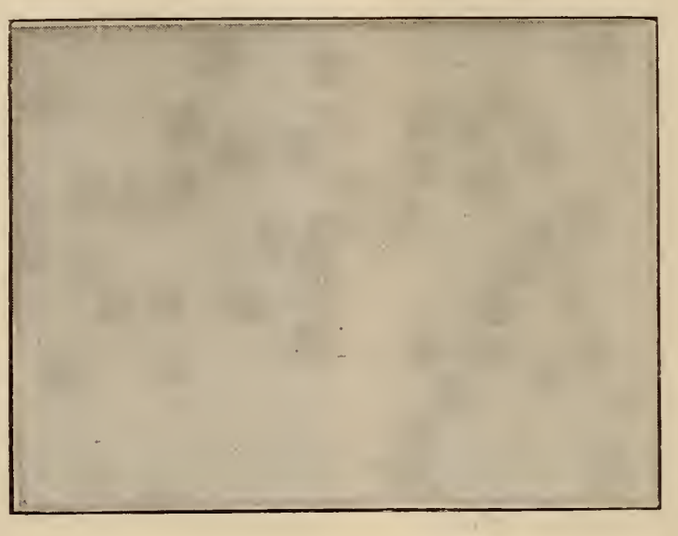


PLATE VIII.

PLATE IX.

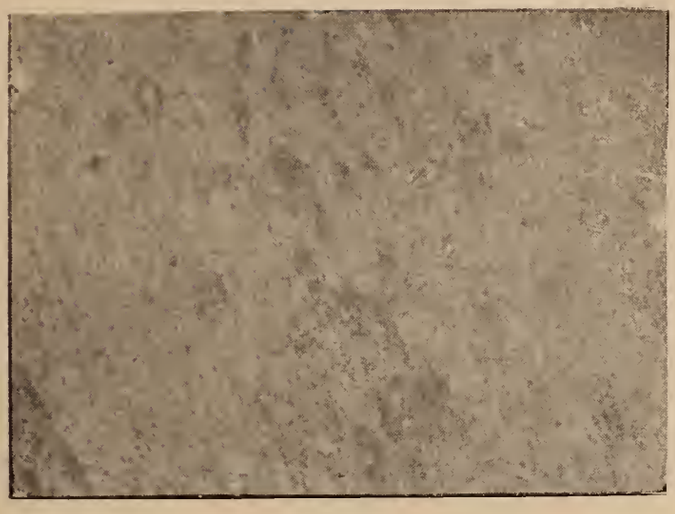


PLATE X.

PLATE XI.

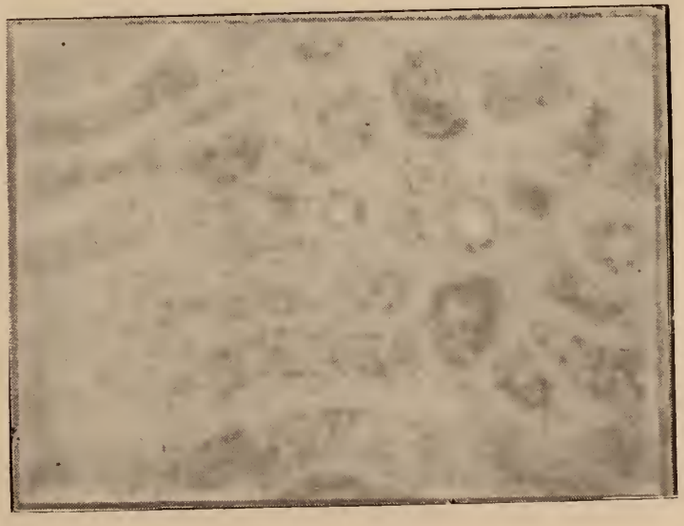


PLATE XII.

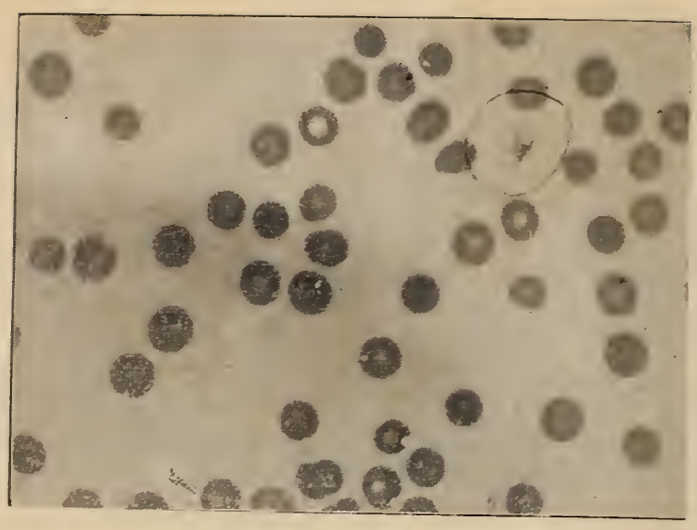
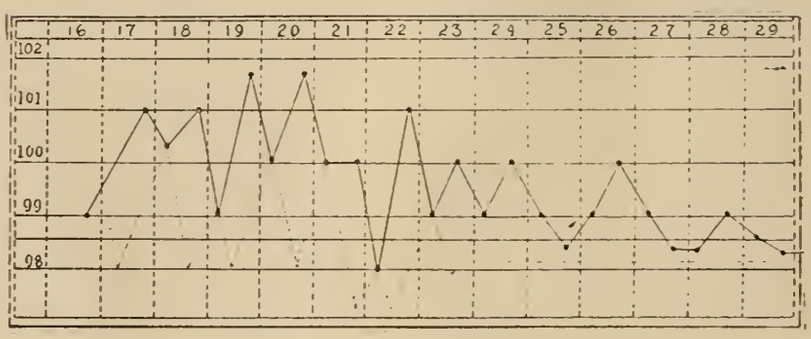
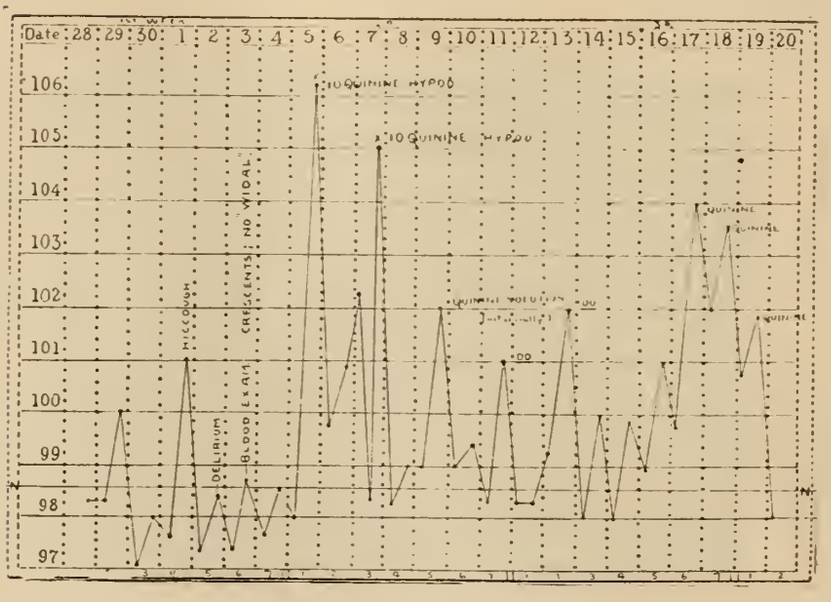


PLATE XIII.



CASE 985.



CASE 1569.

typhoid fever there were only four cases of this fever; two of these have been discharged cured, the other two are able to be up. Among the cases simulating typhoid fever the one of No. 1569 is one of some interest. He was admitted September 28, 1899. Had been sick a week in Little Rock with dysentery, vomiting and daily chills; had abdominal tenderness, slight tympany, gurgling in the right iliac fossa, spleen enlarged and tender; tongue dry, red and hard, with fissures; low delirium at times. The accompanying temperature record is not reliable for the first five days, as he had chill late at night, after the temperature had been taken; he probably had had very high fever each night. His sister, who had means, living in another city, learned of his trouble, came to Memphis, removed him to a private room and called in another physician, who saw him with me on his first visit; he unreservedly pronounced it typhoid fever but agreed to let me examine his blood. The photo-micrograph of the spread and of the Widal reaction, together with the photograph of the Widal reaction with case No. 1723, one of my typhoid patients, forms a most interesting part of the history of this case. In passing these around I would request that all be passed together for comparison. Details that I will not relate are found recorded on the chart and margin of the photographs. Suffice it to say that he recovered under anti-malarial treatment. I forgot to mention that the other doctor retired from the case, after the second visit, on account of illness.

Another case of double estivo-autumnal malaria was of great interest to me. The accompanying temperature chart sufficiently shows the details. (Case No. 985.) Another case of what I may be pardoned for calling, with Dr. Henning, pseudo-typhoid, was under the charge of another physician for three weeks for supposed typhoid. Blood examination showed absence of Widal reaction, and estivo-autumnal organisms; the chart shows the effect of quinin given hypodermatically during the height of the fever on three successive days in the third week. (Case No. 1345.) There were several other cases of pseudo-typhoid with histories very similar, that did not give the Widal reaction, showed malarial organisms, and recovered under the quinin treatment. The diagnosis was made from the temperature chart in most of the malarial cases, blood examinations being made in doubtful cases only.

As a rule, where it could be done, the quinin was given during

the height of the paroxysm; when the temperature curve was irregular, it was given two grams a day, divided into three doses.

Under the head of post-malarial malaise I grouped a number of cases which were admitted with a history of malaria, but developed no further paroxysms. They were usually put upon a simple tonic.

Some of my hematuric cases were quite interesting, but time does not permit going into details, except to mention that one case recovered after going into delirium from uremia; complete suppression had not set in, but the urine had assumed the spring water clearness, with sp. gr. 1001. Morphin and apomorphin were given freely in spite of the prejudice against the former drug in hematuria; I believe nothing so tranquillizes the nervous system; I think the real cause of suppression is excessive purging in the face of the enormous increase in urine solids; precipitation then results, as shown in the photo-micrographs of kidney sections showing the loops of Henle enormously dilated and filled with blood debris.

In closing, I wish to thank Dr. Morrow, the house physician, for his assistance and the records quoted. All praise is due to the Sisters of the hospital for indulging my whims, overworked as they were with the largest summer clinic in the history of the hospital.

Description of Plates and Charts.

Plate I. Widal test with case 1723. 1000 diam. reduced $\frac{1}{4}$; dark areas are agglutinated bacilli; made with same culture, on same day, as case 1569; ten minutes, dilution 1:50.

Plate II. Widal test with case 1569; hanging drop over night, dilution 1:10; notice typhoid bacilli discrete.

Plate III. Liver from a case of malarial methemoglobinuria. Died Sept. 19, 1897, showing cloudy swelling and granular degeneration of the hepatic cells, especially near the central vein; pigmentation; marked round-cell infiltration of the interlobular tissue.

Plate IV. Blood from a case of malarial methemoglobinuria; congestive; first stage, showing methemoglobinuria and small intracellular plasmodia; dark, smutty background due to free hemoglobin.

Plate V. Kidney from case of malarial methemoglobinuria; died Sept. 19, 1897. Kidney, boundary of pyramid; showing chronic interstitial nephritis, a dilated loop of Henle (see diagram on margin), choked with blood debris; ink mark around dilated vas rectum.

Plate VI. Blood from a case of pernicious malaria; died at City Hospital; blood is from the liver, post-mortem; poikilocytosis; three eosinophiles are seen, one in center, two at one margin.

Plate VII. Blood from a case of malarial methemoglobinuria, stage of depression; almost complete decolorization of red cells; section of another spread on margin, showing that same time of exposure shows normal blood plainly.

Plate VIII. Blood spread tertian malaria, taken during pyrexia; diagram on margin shows where plasmodium is.

Plate IX. Kidney from case of malarial methemoglobinuria; died July 16, 1896; cortex; diagram on margin indicates pigmentation of tuft and round-cell infiltration above; general pigmentation and cloudy swelling.

Plate X. Same case, showing a Bellini tubule in pyramidal process, with rod-shaped pigment masses in one angle; highly magnified.

Plate XI. Another hematuric kidney, base of pyramid, showing intense hyperemia of tissue; vasa recta very much dilated; chronic fibrosis very apparent. Died July, 1896.

Plate XII. Same case, more highly magnified, showing choked tubules; descending limbs mostly empty; marked interstitial overgrowth.

Plate XIII. Blood spread from case 1569; diagram on margin indicates crescent, pale spots in some red cells are not plasmodia. This was the so-called typhoid.

History of Case 985.

Admitted July 16, 1899; Lumber boss, aged 35. Had been having chills for several weeks, tertian at first, becoming subcontinuous; had been treated in a river town, but always relapsed. When admitted he had been having daily fever for a week; was much emaciated, had a hacking cough, and believed he had consumption. His physician had advised a change of climate. After a two-hour temperature record he was injected with 5 milligrams of tuberculin without producing any reaction. Blood examination showed intracellular rings and small, hyaline intracellular buds. Quinin hydrobromate, 2 grams daily, had no effect; this was increased to 3 grams, given in four-hour intervals, which resulted in the partial extinction of one of the groups (see black curve—this does not show in the cut, but is the one appearing on the odd days). Warburg's tincture was then given until the fever definitely disappeared. The dotted lines represent the probable fall in temperature if the other group had not raised the temperature before it had time to fall. In tertian intermittent the paroxysm lasts only twelve hours, and in the case of a double infection the fever still has time to defervesce completely before the next paroxysm comes on. The estivo-autumnal paroxysm may last as long as forty-eight hours, hence this curve.

Chart of Case 1569.

The temperature of the first few days is not correct, as the highest fever was at night, and not at first recorded. Note the higher temperature on the odd days. This was entered as a case of irregular estivo-autumnal fever, simulating typhoid, complicated with dysentery.

210, 212 and 214 Randolph Building.

NOTE.—The temperature chart of Case 1345 was inadvertently omitted. The annotations on Chart 1569 should read 1.0 quinin.

Plates III, V, VI, IX, X and XI, while not from this series of cases, were exhibited at the same time as "Photo-micrographs of Malarial Blood and Tissues," and serve to illustrate the pathology of some of the cases.

THE MODERN TREATMENT OF FACE PRESENTATIONS.*

BY GUSTAV KOLISCHER, M.D.
Professor of Gynecology and Obstetrics, Chicago Clinical School.

Face presentations, although not very frequent, are not so rare that it will not be necessary to bestow full attention upon them. As the early stages of face presentations are the most liable to be successfully treated by obstetrical interference, and we do not like to use an internal examination in obstetrical cases without being compelled to, it seems not to be amiss to devote a few words to the external examination.

In external examination we find the head at the pelvic aperture; the skull is elongated to one side; we encounter the greater resistance and the minor parts of the fetus in the same side of the uterus, the resistance being caused by the anterior part of the thorax; the heart sounds also are found at the same side; if the fetal back points to the left, one notices the heart sounds on the right maternal side backward; the fetal back being turned to the right, the heart sounds are heard on the left side and anterior. In the latter position the fetal heart beat can be palpated in favorable cases—that is, if the abdominal walls are very thin and the uterus flabby.

After it is ascertained in this way that an extreme position of deflexion is present, one immediately follows with the internal examination, as in face presentations it is of the greatest importance to secure complete knowledge of all the details. We must learn how far up the face is, in which way it presents itself, furthermore whether the skull is still movable; finally, the pelvimetry has to be carried out with the greatest precision. The skull being still high in the pelvis, one finds the forehead on one side, the mouth on the other side, in the center the root of the nose, on both sides of the latter the bulbi. In the second stage, the face entering the medium planum of the pelvis, the chin descends; the examining finger feels now on one side the anterior angle of the fontanella major, on the other side the point of the chin. The face having entered the

* Read before the Chicago Medical Society, November 8, 1899.

pelvic outlet, the chin is found beneath the symphysis, the forehead resting on the perineum. These findings correspond with the normal spontaneous decursus of face presentations. The face enters the pelvic introitus in a cross position; in further progressing the deflexion becomes increased *ad maximum;* finally the face descends in cross position to the pelvic floor. Rotation of the face, the chin being turned forward, takes place last, as the last preparatory motion before delivery.

As far as the fetus is concerned, the following irregularities are likely to occur: first, the face may place itself in the pelvic introitus with the chin backward; such a position excludes any further descensus of the head; or second, the chin fails to rotate forward, after the face has arrived at the pelvic floor in cross position. In the first case spontaneous delivery is impossible, and may be considered as an extremely rare occurrence.

Searching for the disadvantages of the face presentations, we find the following: The decursus of the labor is a protracted one even under favorable circumstances, which for itself is connected with danger to the mother; second, the head passes under unfavorable circumstances through the vulva, which endangers the integrity of the perineum; the death rate of the children is a high one during the labor, and even if delivered alive the proper nourishing is impaired for several days; the lips and the mouth usually by edema and hemorrhage swell up to such an extent that the babies are unable to suck and even to swallow.

The prognosis of face presentations becomes serious and directly unfavorable if complications previously have been present, or if they are added during the labor. To the complications of the first category belong pelvic contraction even of a slight degree, and constitutional diseases of the mother; to the complications of the second group belong great distension of the lower uterine segment, beginning fetal asphyxia, and irregular mechanism.

Now the question arises, what could be accomplished in face presentations by the obstetric art, in order to secure a more favorable and prompt delivery? This could be answered in this way: We can transform the face presentation entirely by changing the whole attitude of the fetus, that is, by version, or by changing the presentation of the skull, that is, by transleading it from a position of deflection to an occiput presentation; or we can transform an

unfavorable face presentation into a more favorable one by correcting the face presentation in this way, that a spontaneous delivery may take place, or an extraction by means of forceps may be easily performed.

In particular the technic of these different methods can be described as follows: There is nothing special to say about the version —it differs in no way from any other podalic version. So far as the transformation of the face presentations to occiput presentations is concerned, in earlier times already such attempts have been made and different rules have been brought forth; but all of them proved impractical and have been given up, as all these methods have been confined exclusively to influencing the fetal skull, without any regard to the trunk.

Schatz at first called attention to the point that, if we want to effectuate the transformation of a deflected position into a flected position, the skull has to pass through a transient position in which the fetal axis is elongated; to this effect manipulations applied to the skull only are not sufficient—the main point is to dislocate the fetal trunk upward and sideward.

In order to understand the necessary manipulations the following points have to be contemplated: If a face presentation develops at the pelvic aperture, the fetal thorax wanders out of one side of the uterus into the opposite one; if we intend to reconstruct a position of flexion, the fetal trunk has to be induced to return over the same way in an opposite direction—consequently the fetal trunk has to be pushed upward to secure the necessary elongation of the fetal axis, and at the same time the fetal thorax has to be pressed into the other side of the uterus, in order to gain space for the flexion of the head.

Schatz advocated this whole transformation to be performed by external manipulations: one hand grasps shoulder and thorax and pushes both at first upward and toward the side to which the fetal back points; after the elongation of the fetal axis is achieved, the pressure is exerted toward the side of the back only; the other hand is placed on the breech, and this is pushed into the side which was occupied by the thorax. But like all the transformations performed by external manipulations only, this method also is a very difficult one and seems to be reserved for the specialist.

By combining Schatz' and Baudeloque's ideas Thorn recently has developed a method which seems apt to be used by the general practitioner. Thorn's method is performed as follows: The hand which corresponds with the fetal back is introduced into the cervix and the finger tips are placed on the occiput, the other hand is placed on the maternal abdomen and grasps the fetal shoulder from outside. While the external hand is pushing in an oblique direction the thorax from below upward and at the same time into the opposite side of the uterus, the internal hand draws the occiput downward.

Of course all these manipulations have to be done during the pauses of pains. The transformation once performed, there is no danger of a relapse into a deflexion; as to this, an elongation of the fetal axis would be necessary, which is impossible under the influence of the uterus.

In performing the operation the patient is placed on the side which corresponds with the fetal back; the patient remains in this position after the operation.

Usually one succeeds with this operation without any difficulty; only in rare cases, if the patients are very sensitive, it becomes necessary to resort to general anesthesia. One is very often surprised how soon after the correction is accomplished the spontaneous delivery, in occiput presentation, takes place.

The conditions for this correction are: The cervix should be permeable for at least four fingers; the membranes should be ruptured—if they are not, they are torn immediately before starting in with the operation; a slight fixation of the face does not render the transformation impossible; before trying to get on the occiput the face is gently pushed back.

In those cases in which the face has descended to the pelvic floor, and no further rotation of the chin takes place, it is wise to correct this position, as in a cross or oblique position a delivery of a face presentation is almost impossible. It is recommended for such cases, to apply the forceps in the oblique diameter and rotate the head by means of the forceps, after which the extraction may follow.

As to this I wish to say: In the first place, to apply the forceps in the oblique diameter in face presentations is always very difficult, very often impossible; second, the blades of the forceps are work-

ing at a point unfavorable for this purpose; third, there is always the danger of tearing the vagina and the cervix by the great power which can be exerted through the forceps. Therefore it is much more expedient, in such cases, to perform the correction by means of the hand. The flat hand is introduced over the face, the fingers grasp the chin and pull it under the symphysis; after this is done the forceps may be applied.

Concerning the indications the following may be said:

The old rule that in face presentations the expectant therapy is the best, will only hold good in quite favorable and uncomplicated cases. If we consider that the mortality of the children in face presentations is 12 per cent, after the largest statistics, and that in other presentations quite indifferent complications become very serious ones in face presentations, the rule seems to be justified to correct the face presentation in every case which even slightly shows a complication or something abnormal. If there is a pelvic contraction, even a very slight one, the version seems to be the operation of choice.

We should not wait until the face becomes fixed; a fixed face high up cannot be grasped with the forceps if the necessity of a speedy delivery arises.

An absolute indication for interference results if the face presents itself in the pelvic aperture with the chin backward—as in this position the head can, by no means, descend to the pelvic floor.

After the death of the child craniotomy is the most expedient operation. Symphysiotomy has to be performed in case the head of a living child is absolutely fixed in a contracted pelvis, if we want to live up to one of the first rules of the modern obstetrician; we should not sacrifice the unborn life.

92 State Street.

THE PHYSICIAN AS A FACTOR IN THE SPREAD OF CONTAGIOUS DISEASES.*

BY F. S. RAYMOND, M.D.

MEMPHIS.

Within the past ten or fifteen years substantial advancement has been made in the direction of prevention of disease. Sanitation and prophylaxis, in their relation to the practice of medicine, have been given much prominence in our very best medical journals, and occupied the minds of some of the greatest thinkers of modern times. In 1882, or thereabouts, Koch gave to the world the result of his years of study of the cause of tuberculosis, which is, in fact, one of the most masterly demonstrations of modern medicine, and it is only since then, that so much has been said and written about the possible prevention of this great destroyer of mankind by the observance of the plainest rules of sanitation.

Prior to the year 1890 the percentage of deaths from diphtheria in large cities was frightful. About this time different investigators began to be interested in serum therapy, among them Behring, who soon afterward demonstrated the fact that the blood of an immunized animal, when injected into the blood of another animal, would convey immunity.

Today, no one of us would think of treating a case of diphtheria without antitoxin injection. Not only this, but we can immunize those not infected by the use of antitoxin.

Departments of health all over the country have given study and spent money in the investigation of the cause and mode of infection of our most common contagious diseases, and have formulated rules and regulations for the guidance of the profession with reference to isolation, quarantine and disinfection, and we have only to look at the array of facts resulting from such investigation to appreciate the great strides made in preventive medicine quite recently.

But notwithstanding all that has been demonstrated of the value and potency of sanitation, ordinary cleanliness, I may say,

* Read before Memphis Medical Society, November, 1899.

the majority of busy doctors pay very little attention to prevention as far as guarding against infection of the healthy, often visiting infected patients or places.

Boards of health everywhere, and very properly too, forbid children from families where scarlet fever, measles, diphtheria, rötheln, smallpox, or whoopingcough exist, from attending day school, Sunday school, and so on; but no attention is paid to the doctor, who goes and comes as often as he pleases, without any preparation beforehand or the least effort at disinfection afterward, often going next door, or across the street, to make other professional calls.

Now every one knows that the specific poison, or cause of contagion, in scarlet fever, smallpox, measles, rubella and whoopingcough, is not known. In none of these diseases is the virus given off in a definite form. We do know that the infection from some of them at least is conveyed by dogs, cats, books, toys, and even a bouquet of sweet flowers.

Then how can the most fastidious or scrupulously clean doctor say he does not, or cannot, convey infection, unless more preparation is made before, and some sort of disinfection is done after, seeing such diseases.

Of course we know that authorities say that the carrying of contagion in clothes, worn by a doctor, through the air, is rare. Holt says upon this subject: "The transmission of the disease through a third party is not frequent, but numerous instances are on record. The persons most likely to carry it are the doctor and the nurse."

Holt also says upon the subject of diphtheria, when speaking of persons from infected residences: "They may, while healthy themselves, be the carriers of the disease." Surgeon H. R. Carter, of the U. S. M. H. S., who is perhaps as good an authority as we have on yellow fever infection, says: "Ordinary wearing apparel, worn through the air and sun for any considerable distance, is freed from yellow fever." Mark you, he says "ordinary" clothes, also for any "considerable distance." Now, if we knew what Carter means by "ordinary" in this connection, and how far a "considerable distance" is, when being exposed to yellow fever, the proposition would have more weight. Dr. Carter, however, admits that he does not know the possibilities of infection from yellow fever,

and the same may be said of all other contagious and infectious diseases.

Every one must be familiar with the history of outbreaks of smallpox, yellow fever and diphtheria in places where the most careful investigation by the most astute experts has failed to explain the source of infection. I have seen in the country, five miles from even a railroad, diphtheria of the severest form go through a family of children who were never out of the neighborhood in their lives, and the most fertile imagination could not account for the infection—which, to my mind, is very conclusive evidence that we really do not know the possibilities of infection in any of the diseases in question, and forces me to the conclusion that our boards of health should make rules compelling all physicians to protect their bodies by wearing a rubber, or other closely-fitting coat, while in an infected house, and disinfect their hands, face, hair, and beard before seeing any other person, especially a sick person. No physician in Memphis is so busy that he could not find time for the observance of such a rule, if such were made compulsory, and I doubt if any doctor would consider his rights infringed upon or abridged thereby.

As physicians, we often receive the benedictions of thoughtful parents for carrying their little ones safely through one of those dreaded contagious diseases, and although the doctor is entitled to all the thanks and credit he may receive, how much more honor and gratitude is the physician entitled to who prevents disease in the households of his friends and patrons?

I do not believe any physician has the moral right to jeopardize the health or lives of his patrons or others, by failing to observe such simple measures as are herein suggested.

I am heartily in favor of the adoption and enforcement of even more rigid rules, both by city and county boards of health, bearing directly upon the spread of contagious diseases.

SOME REMARKS ON DISEASES OF THE EYE, EAR, NOSE AND THROAT IN THE NEGRO.*

BY E. C. ELLETT, M.D.
MEMPHIS.
Ophthalmic and Aural Surgeon to St. Joseph's Hospital, the City Hospital, the Lucy Brinkley Hospital, the Children's Home, the Shelby County Poor and Insane Asylum, and the Leath Orphan Asylum.

The influence of racial peculiarities on types and frequency of disease is well recognized, and our facilities for observation of disease in the negro is such an everyday matter that I believe we are prone to overlook some interesting and important facts, and not be aware, for instance, that certain diseases are rare in, or peculiar to him, unless our attention is directly called to the fact. By "negro" in this paper I am compelled to include all shades of the colored man, since the pure African is rare among us, and in some instances the original negro blood has been so attenuated by dilution with that of the white, that it almost takes an expert to properly classify a given sample. What I have to say on this subject will pertain almost entirely to the relative frequency of certain diseases, and the negro's inexplicable immunity from others.

I regret, for the sake of accuracy, that I am unable to label this "A Statistical Study." My records are, however, almost altogether those of my private practice, those of my hospital work being in a rather inaccessible form. The negro is such a bird of passage and such an unstable patient, that I believe most of us find it hardly worth while to keep a record of the average negro patient, unless the case be one of peculiar interest. What I have to say, then, will rather be in the way of impressions left by my work among them, and in many instances you will find that your knowledge of them as affected by general diseases will supply the gaps and explain some points in regard to which I have no explanation to offer.

As a preliminary to a detailed consideration of my topic, a few general propositions might be stated once for all, with which I believe all of you will agree:

* Read before the Tri-State Medical Association, November, 1899.

1. As regards the cephalic mucous membrane, the negro enjoys a singular immunity from catarrhal inflammations.

2. The negro has the latch-string of his domestic economy hung on the outside for the entrance of the bacillus of tuberculosis and the poison of syphilis.

3. The negro affords us ample opportunity for the study of the natural history of disease, uninfluenced by treatment.

The Eye.

Affections of the lids are not common. Marginal blepharitis, often dependent on errors of refraction, is, on that account, rare. Epithelioma is, I believe, unknown, though I have seen one case of rodent ulcer in a young mulatto. This case has been reported by Dr. Krauss and myself in the *Annals of Ophthalmology*.

Lachrymal Affections are relatively rare, for reasons that will be mentioned later.

Affections of the Conjunctiva in the negro present a few peculiarities. Acute catarrhal conjunctivitis (cold) is relatively very rare. Trachoma (granular lids) is almost unknown, though instances of it are seen. Phlyctenular or scrofulous conjunctivitis is the commonest disease of the conjunctiva with them, and is more prone to affect the part of the conjunctiva lying next to the cornea than it is in the white.

I have seen much less gonorrheal conjunctivitis, both in the adult and the infant, in the negro than in the white.

Corneal Affections probably constitute the majority of eye diseases in the negro. As a child he is very susceptible to phlyctenular or scrofulous keratitis, probably because his tissues are all easily affected by tubercular processes. Later in life corneal ulcers of all sorts and sizes and many atypical forms of interstitial inflammation of the cornea are seen. It must be a daily occurrence with all of you to see negroes with white corneal opacities, the result of former ulceration, and constituting his commonest cause of blindness. Neglected, these ulcers often perforate the cornea, impairing the sight to a greater or less degree. This prevalence of corneal affections in the negro has been observed by other Southern writers, notably, Ray, of Louisville, and is one of the points which I wish to emphasize.

The Uveal Tract, the name given to the choroid, ciliary body and iris, rivals the cornea in supplying cases of eye disease in the negro. This is especially true of the iris, which bears the brunt of the effect of the syphilitic poison on the eye. While I cannot give figures bearing on the subject, I am convinced from my experience that plastic iritis, as a manifestation of secondary syphilis, is one of the commonest of eye diseases in the negro, and is frequently complicated with cyclitis. Simple cyclitis must be rare, and I do not recall a single case. Ray, of Louisville, has found gumma of the iris and ciliary body quite frequently, but I have not noticed it more frequently than in the white. The iritis being often neglected, frequently results in occlusion of the pupil by lymph and consequent blindness.

As a peculiarity of the eye of the negro, it might be mentioned that the excessive amount of pigment in the choroid makes the light reflex as seen by the ophthalmoscope rather dim, and the eye-ground itself is, in dark subjects, often almost slate-colored.

The Retina presents no peculiarity worthy of note. Retinal diseases are not common in any class of patients, and I think I have seen relatively as many affections of the retina in negroes as in whites. I recall one case of retinitis pigmentosa, two or three of albuminuric retinitis, and two or three of hemorrhagic retinitis (retinal apoplexy), but few others.

The Crystalline Lens is prone to undergo cataractous degeneration in the negro. I see and operate on very many more cataracts in the negro than in the white. This cannot be explained by the theory that cataract is brought on by eye strain and uncorrected errors of refraction, but is due, I think, to the fact that the negro works hard, is much exposed, often poorly fed and clad, and in general takes such poor care of himself that senile changes, such as cataract, are apt to develop in him early and with considerable frequency. Once started, I think cataracts ripen, i.e., the opacity involves the whole lens, with much greater rapidity than in the white subject. Soft cataracts in the young are relatively less common than in the white.

The Optic Nerve shows atrophy and retro-bulbar inflammation with a frequency which is probably to be explained by the wide prevalence of syphilis in the race. Idiopathic atrophy, i.e., independent of any recognized cause, is rather frequent, and is proba-

bly often due to a syphilitic infection of which we can get no history. I do not recall now a single typical case of toxic blindness, i.e., from quinin, alcohol, lead or tobacco.

Primary Glaucoma is rare in the negro. I have seen but two instances, one of double typical glaucoma in an elderly mulatto woman, the other acute glaucoma in a young negress. I have had, at different times, several cases of hemorrhagic retinitis under observation, but have not observed any of them pass into hemorrhagic glaucoma.

Errors of Refraction are not usually of much importance in the negro. He, as a rule, does not use his eyes enough to be troubled by the small amount of hyperopia and hyperopic astigmatism which he has doubtless acquired along with his admixture of white blood, while myopia is quite rare in them. I have seen, however, a few cases of a high malignant sort of myopia among them, one being in both eyes of an almost pure African, and a rather large number of similar cases affecting one eye. Few negroes, however, have applied to me for the correction of errors of refraction, or presenting any of the evidences of eye strain.

Muscular Anomalies, from the various forms of lack of balance in the eye muscles to positive squint, are very rare. In this observation I find support in the opinions of two well-known Southern eye surgeons, Kollock, of Charleston, and Bruns, of New Orleans. I am sure that I have never examined a single negro who was the subject of the ordinary sort of crossed eyes, though I remember to have seen two on the street who were apparently so affected. It is more than likely that these two were paralytic cases, since paralyses of the eye muscles, due to syphilis, are by no means rare. Indeed, they are very common, and yield gratifying results to large doses of the iodides.

Blindness in the negro can practically be classed under three heads: 1. Corneal opacities.

2. Neglected iritis.

3.. Optic nerve degeneration.

The first and second are rather common. The former is not wholly preventable, while those from neglected iritis can be practically wholly prevented by proper treatment of the trouble in its acute stage.

From what I have said a practical point in treatment may be deduced as follows:

In inflammatory eye affections of the negro, where a satisfactory diagnosis cannot be made, the local use of atropia, combined with the administration of mercury and iodide of potash, separately or in combination, will, in the majority of cases, yield a good result. The rarity of glaucoma makes it at least improbable that the atropia will produce any deleterious results.

Diseases of the Ear, Nose and Throat.

Diseases of the ear, nose and throat have a close anatomical relation. Prior to any remarks on them in detail, I would repeat what I said before, that the negro enjoys a singular immunity from catarrhal diseases, acute or chronic, the only explanation for this that I can think of being that he is blessed with a roomy nose and naso-pharynx, and the space is so wide as not to be encroached on to a symptom-producing degree by an ordinary amount of thickening of the tissue. No less an authority than Lenox Browne has recently said that a roomy naso-pharynx predisposes to naso-pharyngeal disease, but this is certainly not true of the negro.

Accessory Sinuses. I recall now but two cases in negroes in which any of the so-called accessory sinuses were involved. One was a case of maxillary antral disease, and in the other the anterior ethmoidal cells were affected.

The Ear.

Few cases of acute or chronic ear disease in the negro have come under my notice, and it is probably a common observation that deafness is much less frequent among them than among the whites. As a rule they are prone to neglect middle ear suppurations, thus yielding a relatively large number of mastoid cases.

My observations are, I must confess, less extensive in this department than in the eye. I not only do not cater to this practice, and rather discourage it, but am often, for obvious reasons, compelled to refuse to treat them. I have, however, probably examined, if not treated, my share.

The Nose and Throat.

A few cases of hypertrophic rhinitis, and a tolerably large number of syphilitic cases, will include most of the cases of nose and throat disease that I have seen in the negro. I do not know that

tonsillitis is particularly rare, but I do not think that I have amputated the tonsils in more than two cases, and I have seen very few others who needed it.

Adenoid Vegetations in the Naso-Pharynx do not Occur in the Negro. I have watched this point very carefully, in connection with a collective investigation on the subject of adenoids which I have recently made, and I believe this statement is correct. The only corroboration of this that I can find is from Dr. Calhoun, of Atlanta. I do not know what the experience of my colleagues here is.

The infrequency of tonsillar hypertrophy and the probable nonexistence of adenoids opens an interesting field for speculation.

The negro is peculiarly prone to scrofula and its big brother, tuberculosis. Scrofulous eye disease, facial eczema, scrofulous adenitis, etc., and all manner of tuberculous manifestations, are exceedingly common in the negro. Enlarged tonsils and adenoids are but one expression of what the Vienna pathologists call the "habitus lymphaticus," a diathesis closely related to, if not identical with, scrofula. Why the negro should carefully omit to present these along with the other manifestations of scrofula is difficult to understand, unless it is due to the configuration of the skull and the resulting wide nasal chambers and pharynx, of which mention has been made.

I have seen a few cases of atrophic rhinitis, which seemed to be syphilitic. The same cause has underlaid practically all of my laryngeal cases, except a few cases of laryngeal tuberculosis.

The negro is not an especially inviting subject from our point of view. Apart from an esthetic side of the question, he is in sickness a superstitious, disobedient, untruthful, ungrateful, unprofitable, and generally disagreeable patient. But to us he personifies "The White Man's Burden," and since we cannot shirk the obligation which his presence imposes, we may as well study his peculiarities and try to fit ourselves to make the best of what is usually a bad bargain. Not the least of his peculiarities are those which he presents as a pathologic specimen, and I hope from this point of view I have succeeded in bringing out sufficient that is of interest to justify me in presenting the matter to you.

Porter Building.

RECURRENCE OF TYPHOID FEVER, WITH REPORT OF A CASE.*

BY L. L. MEYER, M.D.
MEMPHIS.
Late House Physician and Surgeon to New York City (Charity) Hospital, Pathologist to the City Hospital, Visiting Physician to Leath Orphan Asylum, etc.

The question of a second and even a third attack of typhoid fever has been definitely settled, inasmuch as authentic cases have been reported by reliable observers, though it is generally conceded that one attack confers at least partial immunity from other attacks. Hare[1] speaks of a patient who had one attack at 9 years of age, a second at 17 and a third at 19. Moore[2] records the case of a patient who suffered from typhoid at 15 years of age and again at 29, and finally from a relapse after this second attack; and Leidy[3] reports the case of a patient who had an attack of enteric fever at 16 years, a second attack six months later, and a third at the age of 34 years, and this followed by four relapses, with final recovery, though complicated by intestinal hemorrhage.

The case which I have to report is as follows:

Patient, W. E. G., white, aged 37, presented himself at my office November 17, 1899, with the following history: About November 2 he began feeling tired, had frontal headache, malaise, etc., and on taking his temperature found he had fever. He consulted a physician, who put him on quinin, and later, finding the temperature did not yield, he put him on arsenic, iron and strychnia. Finally, not getting any better, he came to me. During this time, about fifteen days, he had not been confined to his bed, but was up and at work. Upon walking into my office he said, after exchanging the courtesies of the day: "Doctor, I believe I have typhoid fever." I asked him why he thought so, and he answered that he had had two attacks previously, and that he now felt just as he had felt on those occasions. This aroused my interest, and upon going into his previous history in detail, it developed that in 1879, when he was 17 years of age, he had a spell of fever diagnosed typhoid by his physician, a man in whose diagnostic ability I have every confidence. He was in bed six weeks, and it was two months before he was again able to be out. The symptoms he described conformed with those of typhoid. In 1888 he again had a spell of typhoid fever, which confined him to his bed from the middle of October to Christmas. He describes his symptoms accurately, even to noting the spots on his abdomen, and being a man above the average intelligence, I have confidence in his observations.

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* Read before Memphis Medical Society, December 5, 1899.

An interesting coincidence in this case is that the patient's father was taken ill with typhoid shortly after his mother became pregnant with him and died from intestinal hemorrhage seven or eight months before the patient was born. The patient complained, when I first saw him, of frontal headache, loss of appetite, malaise, slight cough, pain in the left lower axillary and right inguinal regions, constipation, and loss of strength. Examination showed temperature 100½° F., pulse 84, not dicrotic, tongue coated and red at tip and edges, spleen tender to pressure and enlarged so that it could be felt at margin of ribs and below, some tenderness and gurgling in right iliac fossa, no tympanites. On the surface of the abdomen and chest there were ten or twelve typical typhoid spots. A few dry and moist râles were found over both lungs. Blood examination gave a Widal's typhoid reaction, and showed no evidence of malaria. There was some blood destruction. Other interesting features of this case are:

That the morning temperature was never above 100°, evening temperature never above 102° (and that only on one or two occasions), and the comparative freedom from all disagreeable symptoms except a slight headache and occasional constipation. I attribute these unusual features to a partial immunity conferred by previous attacks of typhoid. The patient is now entirely well, his temperature having lasted about three and one-half weeks.

I desire to state for those who question the clinical diagnosis that in the first sixty hours after I saw this patient he took over 100 grains of quinin with no effect on his temperature, thus eliminating malaria in the diagnosis, as I am a firm believer in the dogma that any continued remittent fever resisting large doses of quinin for several days is not malarial, especially, if no plasmodia are found in the blood after repeated examinations, and I at once suspect typhoid.

Again, some may question the value of Widal's reaction in a case having previously had typhoid. There was an interim of eleven years between this and his last attack, besides the clinical symptoms of rash, enlarged and tender spleen, pain in iliac fossa and temperature confirmed the diagnosis beyond a doubt.

Of course the doubt also arises as to the previous attacks having been typhoid, but, as I have said before, the physicians who attended him were men of undoubted ability, besides, the patient himself, an intelligent man, remarked the striking similarity of the subjective symptoms between this and previous attacks.

Bibliography.

[1] Hare—Medical Complications and Sequelæ of Typhoid Fever, page 264.

[2] Moore—Dublin Journal of Medical Science, April, 1893 (Hare).

[3] Leidy—International Medical Magazine, August, 1893 (Hare).

CORRESPONDENCE.

Editor Memphis Lancet: MEMPHIS, Dec. 9, 1899.

MY DEAR DOCTOR—Will you do me the justice to correct a grave error in the report of my paper on Vesical Calculi in your December issue? You state it as my opinion that the large majority of stone cases are found among the negro race—which is incorrect. What I did say along this line was this: "That the negro race furnish a larger percentage of cases than they have heretofore been accredited with." Quite remote from what you publish, as you can readily see by comparison. Thanking you, etc.,

I am yours truly, F. D. SMYTHE.

[In regard to the above, a request was made of Dr. Smythe, as well as of every other gentleman on the program of the Tri-State Medical Association, to furnish us an abstract of his paper for use in the proceedings, the idea being to prevent in this way any mistakes, and to give an account of each paper satisfactory to its author. Dr. Smythe promised to give us this abstract but failed to do so, hence we were compelled to rely on the notes taken by our reporter, and in this way the mistake occurred.—EDITOR.]

MANAGEMENT OF NORMAL LABOR.—George P. Shears (*Obstetrics*, October, 1899) brings out the following points: The avoidance of too frequent and unnecessary examinations and routine rupture of the membranes, the needlessness of the Credé method of expression of the placenta in the majority of cases, needless dread of clots, the necessity of macroscopic cleanliness, and avoidance of complete reliance on chemical disinfectants, etc. He also thinks that the importance of perineal lacerations of the first degree is much exaggerated, and that primary perineorraphy has had too little attention given it as a factor in the production of infection. He thinks that the day of the use of douches is past, excepting in suspicious cases, and the tea and toast diet is going, as is also the ten days recumbency. The puerperium, while still defined as a period of unstable equilibrium, is still sufficiently stable to get along with less interference. He does not wish to say that these cases should be left not merely to nature, but also to ignorance, but that normal cases should be watched more than meddled with by a competent scientific practitioner.—*Journal of the American Medical Association*, Nov. 11, '99.

THE

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EDITORIALS.

THE USE OF PROPRIETARY MEDICINES.

As recorded in the last number of the LANCET, the Memphis Medical Society has, by resolution, condemned the use of proprietary medicines. We think that an injustice has been done the manufacturers of a large number of medicines by that resolution, and in behalf of those to whom we think this injustice has been done, we wish to protest against lumping all together and denouncing them. Many of the antipyretics in common use today—indeed all except acetanilid—are proprietary remedies, made often by a secret process and known by a copyrighted name, but whose chemical composition and physiologic action are well known. The same is true of many substances recently introduced to replace iodoform, as well as of the organic silver compounds. It is only by protecting his product under a copyrighted name that the manufacturing chemist justifies the cost of its production. Again, there are certain compounds whose formulæ are vouched for by reputable houses which from a standpoint of pharmaceutical elegance and therapeutic activity surpass the extemporaneous compound, and if we are true to our duty of doing what is best for the patient, we will use them.

Recent investigations in the drug stores of this city have shown, unfortunately, a wonderful discrepancy between what the tinctures

of opium, belladonna, nux vomica, etc., were, and what they should have been. Knowing this, is not a physician wise to insist on the product of a reliable manufacturer being dispensed rather than the home product of a pharmacy of shady reputation? Is it not better for him to leave the pharmacopœia altogether under some circumstances, and use a proprietary remedy, such as ergotole, McMunn's elixir of opium, etc., which are always the same?

The spirit of the resolution is good; that is, we should not depend too much on readymade formulæ, nor learn therapeutics from circulars and drummers. In this much we hope it will be observed, but it cannot and will not and should not deprive us and our patients of the benefits of modern pharmacy, and we feel sure that this was not the intention either of the one who proposed the resolution or those who voted for it.

REPORTS OF SOCIETIES.

PROCEEDINGS OF THE MEMPHIS MEDICAL SOCIETY.

Regular Meeting, November 22, 1899.

The President, Dr. B. F. Turner, in the chair.

Present were, Drs. Turner, Alfred Moore, Krauss, Crofford, Heber Jones, Raymond, Farrington, Buford, Barton, Kane, Haase, W. B. Sanford, Ellett, Holder, Venn, and F. A. Jones.

Dr. F. S. Raymond read a paper on *The Physician as a Factor in the Spread of Contagious Diseases.* (See page 13.)

Dr. Wm. Krauss said the subject is a neglected one, and the danger lies in this fact. Guiteras says regarding yellow fever that he takes no precautions and has never been instrumental in spreading the disease. But Guiteras is a rapid worker, and only stays a few moments in the patient's room. Diphtheria, smallpox and scarlet fever are most apt to be carried. With smallpox most physicians take due precautions. Hildebrand's classic case was quoted, where an overcoat carried the poison of scarlatina for eighteen months. In diphtheria the contagion is only transmitted by the coughing out of particles of the membrane. An oilcloth coat and proper cleansing of the hands would be sufficient precautions for the physician to take against diphtheria. In scarlatina the conta-

gion is in the air. Sanitary measures have lessened its transmission. It is wrong to differentiate between contagious and infectious diseases, but we should divide them into transmissible and untransmissible, and adopt rules for individual diseases (transmissible). Meningitis is not ordinarily contagious, because the seat of disease is not exposed to the air. Tuberculosis and typhoid fever should be notifiable diseases.

Dr. E. C. Ellett spoke of the danger of transmitting disease by thermometers, tongue depressors, etc. The former should be washed before and after using, and best in the patient's presence. Tongue depressors, etc., should be sterilized by boiling or by some antiseptic solution (formalin) and a separate set kept for use on cases known or suspected to be contagious, especially syphilitic.

Dr. Heber Jones knows of one case in which a physician carried contagion. It was scarlatina carried to a puerperal woman, with fatal result. He regards the oilcloth coat, disinfection of hair and beard, etc., as impracticable, and only necessary in cases of smallpox. Short visits, careful washing of hands, and avoidance of disturbing the bedding, usually suffice. Unnecessary fondling of other children when attending a contagious disease should be avoided. Vaccination has made the occurrence of smallpox a municipal disgrace, though we here have to deal with the negro population, among whom nearly all our cases occur. Doctor's families do not develop contagious diseases more than others. He prefers a flat, smooth tongue depressor, and relies on ordinary washing to clean it, though he has a separate one for syphilitic cases.

Dr. Alfred Moore has refused to attend other cases when seeing diphtheria, but does not think this is often done. Often only one case will occur in a house, a fact we cannot satisfactorily explain.

Dr. Marcus Haase sees a good deal of smallpox in his official capacity, and when attending them he gives up other practice and wears a rubber coat. He thinks he once carried smallpox to a person whom he was called to see as a suspicious case. She developed smallpox fourteen days later. Tuberculosis and typhoid are not notifiable, and he does not think physicians would report them if they were, but when the board of health knows of a case of typhoid they investigate the premises to see if they can discover the cause. Their information is derived from the specimens sent to the bacteriologic department.

Dr. W. B. Sanford thinks it strange that physicians do not oftener contract and convey diseases. He thinks the rubber coat fits too loosely to give good protection. The physician should be subject to the same rules that laymen are, and he should bathe and change his clothing after seeing a case of contagious disease.

Dr. Heber Jones exhibited a thermometer with the index enclosed, the surface being smooth and easy to clean.

The President thinks the public is being educated on these subjects, and physicians should and will be compelled to adopt some such cloak as is worn by students in contagious hospitals, i. e., with close-fitting wristbands and hoods. He observes the precaution of taking a bath and changing clothes after seeing a contagious case, but realizes the impossibility of this at times.

Dr. Ellett said that there were holders devised to carry glass plates and attach them to tongue depressors to protect the physician from having contagious matter coughed into his face, and at the same time not obscuring the view. These have not come into general use.

Dr. Raymond agrees with Dr. Krauss that we ought to abandon the classification of contagious and infectious diseases. He also agrees with what was said about the sterilization of thermometers, instruments, etc. He thinks he once carried contagion to one of his own family. The possibility of our contracting and conveying these diseases should not be forgotten. He mentioned the case of Dr. Will Jones, who disbelieved in vaccination, contracted smallpox from a patient and died.

Dr. T. J. Crofford reported *Some Anomalous Cases of Appendicitis* as follows:

Case I. A woman, aged 20, had been in bed three years with chronic diarrhea, afternoon fever, loss of flesh, abdominal tenderness, greatest over the appendix, and pain on sitting up. Operation revealed a small stump of appendix under the cecum, with a lumen. It was removed and weighed seven grains. Patient has regained her health and forty pounds of flesh.

Case II. Man, aged 35, practically an invalid from pain in the *left* iliac fossa for a year or two. A tender lump was felt at the site of the appendix, and operation discovered a large inflamed and adherent appendix. Recovery.

Case III. A girl, aged 18, had repeated attacks of appendicitis, resulting in invalidism and neurasthenia. Operation after the ninth attack. The appendix was retro-peritoneal and not much inflamed but was removed. After three years her health is better, the tenderness is gone, but she has had some mild attacks of appendicitis (?)

Case IV. A woman, aged 22, had had pain in the right side for three years, confining her to bed one year. There was no tumor, but operation a week ago showed a large chronically-inflamed appendix containing five fecal masses. The patient is doing well.

Case V. A recent case—that of a man in his second attack of a week's duration with complete obstruction of the bowels, due probably to inflammatory paresis. The patient will probably die, but an operation would do no good—in fact his chances are better without it.

Dr. Sanford thinks medical opinion is about to turn from the surgical treatment of appendicitis, which is to be regretted, since the surgical is the only radical treatment. The question is when to operate.

Dr. Alfred Moore reported a case with somewhat anomalous symptoms. Operation on the eighth day showed a gangrenous appendix. Recovery.

Dr. E. M. Holder saw Dr. Crofford's third case, and thought the pain was due to traction by the full cecum on the adherent appendix. She has had hysterical attacks since the operation, but no signs of appendicitis when he has seen her. He thinks the tendency now is to be more conservative as regards operation, and many cases undoubtedly recover without it. The personal equation must be taken into account.

Dr. Krauss said that one edition of Gray's Anatomy says that the appendix sometimes has a mesentery, implying that it is usually retro-peritoneal. He would rather take his chances with the medical treatment of appendicitis than with operation at the hands of the occasional operator. He would prefer to be treated by operation at skilled hands.

Dr. Frank Jones asked if the lungs of Dr. Crofford's first patient were examined. He thinks it was a case of tuberculosis of the mesentery, relieved by celiotomy and irrigation. He does not think surgery is retrograding. Czerny's rule is that the first attack

of appendicitis belongs to the physician, the second to the surgeon, and it is best to operate in the interval.

Dr. Raymond was glad to hear Dr. Crofford say he had found a non-operative case. He thinks that many, probably most, cases would recover without operation.

The President said that many cases were purely medical. He has seen some where operation was thought to be imperative, but was refused, and the patient recovered.

Regular Meeting, December 5, 1899.

The President, Dr. B. F. Turner, in the chair.

The following members were present: Drs. F. A. Jones, Holder, Raymond, Alfred Moore, Moore Moore, Turner, Sale, Krauss, Hall, Venn, Henning, McKinney, Braun, Smythe, E. E. Haynes, W. L. Haynes, Goltman, Buford, Barton, W. B. Sanford, Lane and Meyer.

Dr. E. E. Haynes read the first paper on *When to Operate in Appendicitis.* His experience leads him to regard the disease as a surgical one. The question is not whether to operate, but only when to operate. He discussed the probable etiology and pathology and the anatomy, to show how readily invasion of contiguous tissues can take place, which cannot be predicted nor differentiated from uncomplicated cases. The time to operate is as soon as the diagnosis is made. If invasion of surrounding tissues has begun, operation may prevent further invasion. On resolution being established it is the correct procedure to wait, and operate in the interval. Special contraindications may exist in given cases, but these must be decided by the surgeon. The most unanswerable argument in favor of the operative treatment is that the operative death rate is less than the medical death rate.

Dr. Joseph Venn is sorry that the essayist is an extremist, when the best men have begun to be more conservative. He thinks some cases absolutely require operation; the general run of cases get well without it.

Dr. B. G. Henning had been associated with operators, several years ago, and did not see any better results than he gets now by the medical treatment. There are four forms of appendicitis. Regarding the mild catarrhal cases, there is no excuse for operating upon these; suppurating cases generally wall themselves off and

can then be opened like a simple abscess in any other situation. Fulminant cases die under any treatment, and will die if operated upon at once.

Dr. E. P. Sale believes in the middle of the road plan. Operation is the only chance for fulminant cases, and he has had some cases saved by operation. These cases have the characteristic face, which is pinched, shock, thready pulse, sighing respiration, etc. Subacute catarrhal cases need no operation, but surgical supervision, dry warmth to parts (which he prefers to cold), turpentine as an intestinal antiseptic, combined with carminatives. The only cases he has ever lost acted imprudently. He related the case of a patient who backed out from the operation of opening the pus sac, and who recovered by spontaneous rupture into the bowel.

Dr. Alfred Moore regards this as a surgical disease, if only for surgical supervision. Not all cases are operative cases; the death rate from anesthetics is greater than generally admitted, and is a factor to consider in mild cases.

Dr. Haynes summed up the discussion. His paper was suggested by the experience of himself and others, whose patients he had seen. He related cases in point that he had not operated on. He would like to know how the attendant is to judge of the severity of the case before alarming symptoms had developed, or how one can decide whether a given case is one for operation without cutting the patient open to see. A case in point was mentioned, of a child with very mild symptoms, in which he did not urge the operation, which afterward formed a pus sac, but, instead of progressing like Dr. Henning's case or Dr. Sale's case, ruptured and infected the peritoneal cavity, destroying the patient. The risk is too great to trust such cases to chance. It is not the province of the physician to take chances, but to avoid them; this is true conservatism. The risk of the anesthetic must be accepted.

Dr. L. L. Meyer read a paper on *Recurrence of Typhoid Fever, with Report of a Case.* (See page 22.)

Dr. Sale related several cases; he did not believe even the presence of malarial parasites excluded typhoid fever.

Dr. Krauss, upon request, related some anomalous cases of malaria to show that the clinical symptoms may lead into error. Neither a single blood examination nor the Widal test is conclusive, unless in the former instance the stage of the paroxysm is consid-

ered, and in the second something is known about the state of the culture used, its reaction, and the degree of dilution and time of exposure. He did not doubt the essayist's diagnosis nor observation, nor the possibility of recurrences, as the literature is full of them, but would take exception to the dictum that 100 grains of quinin in forty-eight hours eliminates the malarial element.

Dr. Venn covered the subject of immunity as relating to typhoid fever.

Dr. Henning was surprised, in his service at the City Hospital, at the frequency of the coëxistence of the malarial organism and the Widal reaction, as returned by the pathologist of that institution. Osler says that in over 2000 cases only 3 showed a double infection, while 10 per cent. of his cases were mixed. The death rate of typhoid fever is 10 to 15 per cent., but he never loses a case of the mixed infections. Surely, if they were typhoid some of them would die ; nor are they protected from subsequent similar attacks. Gurgling in the right iliac fossa is due to liquid diet and gas, and has no diagnostic significance ; diarrhea and bloody stools occur in connection with malaria.

Dr. M. Goltman said that the Widal reaction was neither absolutely positive nor negative evidence. The estivo-autumnal parasite is very resistant to quinin, and failure to break the paroxysm with huge doses of quinin does not exclude malaria. He did not doubt the correctness of the essayist's diagnosis.

Dr. Sale regards most of our summer fevers as typhoid. He does not make the diagnosis upon one symptom, but the grouping of most of the important signs constitutes a safe diagnosis.

Dr. Meyer admits the possibility of double infection, though rare, and thinks the Widal reaction is conclusive of present or past infection with typhoid bacillus. He considers any fever not malarial if quinin is given in large doses for several days with no effect on the temperature, especially if several blood examinations are negative. He differs from Dr. Henning, and thinks typhoid more common than supposed.

PROGRESS OF MEDICINE.

Clinical Diagnosis of Typhoid Fever.—The *Medical News*, Nov. 11, 1899, gives the following abstract of a paper by Wm. Osler, read before the N. Y. State Medical Association:

There is no one symptom, nor two symptoms, nor three symptoms that are always present in typhoid fever. Any or all of the usual symptoms may be absent. We do not judge by a few positive signs. The diagnosis is a rational one, and must be often made on circumstantial evidence. Yet few diseases are so certain in their diagnosis as typhoid fever. These are practically the words with which Elisha Bartlett begins his chapter on the diagnosis of typhoid fever written in the year 1842. They are as true today as they were then, despite all the work that has been done on the subject since.

For instance, very often we meet with cases in which for five to eight days there is slight fever, and in which we sometimes can feel the edge of the spleen. If rose spots do not develop we are apt to call them simple continued fever. In a number of cases, however, after the cessation of the fever, patients have given the Widal reaction, showing that it was really typhoid fever. A recent epidemic in Switzerland was very interesting in this particular. Some thirty cases of frank typhoid fever were treated in the hospital. Twelve other patients, who had slight headache, moderate temperature and general malaise were not put to bed because they were considered not to have the disease. The application of the Widal test after their convalescence showed that they had had typhoid fever. The Widal test will undoubtedly greatly restrict simple continuous fever as we know it now.

Too much insistence has been given to the abdominal symptoms of typhoid fever. It is very possible for the disease to occur absolutely without abdominal symptoms. Out of thirty-five cases that have been under his care during the last month only four patients have had distinct abdominal symptoms.

Besides the enteric type there are forms of the disease in which the cerebro-spinal, the pulmonary and the renal symptoms are of most importance. Many cases of sporadic cerebro-spinal meningitis

are undoubtedly typhoid fever of the meninges. Very often the typhoid fever is concealed by the occurrence, in the midst of a more or less continuous fever, of a consolidation of one or more lobes of one or both lungs. Undoubtedly certain cases of so-called acute nephritis are really renal typhoid. The disease may run on without other symptoms until the development of rose spots betrays the nature of the disease. There may be no fever at all, or it may begin very abruptly; there may be rose spots, intestinal symptoms may be entirely absent, and so there may be no diazo-reaction. The Widal test may be positive only very late in the disease, or may not occur until after the fever has ceased. There may be no leukocytosis.

Repeated chills usually means malaria. The differential diagnosis of malaria is not so difficult as has been thought. No continued fever diagnosed as malaria here in the North in former times was probably anything but typhoid. The country was shocked during the Spanish-American war by the discrepancy of reports and the disagreement of doctors with regard to the existence of typhoid or malaria in the camps. It was not the army surgeons who were to blame, nor the profession of the country, but the teachers at our medical schools who have not insisted enough on the distinction between these two diseases. Malaria is such an accommodating word. It covers such a multitude of diagnostic sins. It was at least as consoling in its way as the unctuous word Mesopotamia to the old woman in the story. Above Mason's and Dixon's line an intermittent fever that does not yield to quinin is not malaria. Practically only tertian fever exists at the North, and this yields readily to quinin in thirty-six or forty-eight hours. At the South we have the estivo-autumnal type which gives rise to a remittent fever. The curve reaches a fastigium and then does not vary by a degree perhaps for days. The temperature chart is like a map of the Pennsylvania Railroad; that of ordinary malaria is more like the multiserrated line of the Baltimore & Ohio. The estivo-autumnal type may resist quinin for two or three, or even four or five days. The parasite of the disease too is harder to find, so that there is more reason for mistake in diagnosis. Out of a thousand cases observed at Baltimore at Johns Hopkins in only one case did malaria and typhoid occur together. In general and obscure febrile cases it is better to suspect typhoid than malaria. Our position in the matter

should not be the Anglo-Saxon one of thinking the case innocent of typhoid until proved, but rather the Gallic position of considering the case guilty of typhoid until it is demonstrated to be innocent. Two works should be on every physician's table—Keen's "Surgical" and Hare's "Medical Complications of Typhoid Fever."

Remarks on the Surgery of the Gall Bladder.—The *Medical Record*, Nov. 25, 1899, gives the following abstract of a paper read by M. H. Richardson before the N. Y. Academy of Medicine:

Surgical relief, Dr. Richardson said, was called for whenever gall stones were believed to be present, for nature was a clumsy operator in such cases. The chief dangers were from shock, hemorrhage and sepsis. On the side of operative intervention the dangers were trivial and the chances of recovery great, whereas on the other side were many and grave dangers and uncertainties. Even in cases of suspected malignancy exploration was indicated, because one often found only gall stones, and could then give complete relief. The patient should be given the benefit of the doubt. His custom was to make a vertical incision between the fibers of the rectus, at first only large enough to admit of the introduction of the fingers. The gall bladder should be aspirated, for sometimes stones that could not be felt at all before such aspiration could be easily detected after this operation. In most cases considerable hemorrhage occurred from the gall bladder after the introduction of the scoop or even of the finger. It was especially liable to occur if the gall bladder had been overdistended. Having removed from the gall bladder all of the stones, the bladder should be temporarily packed with gauze while a digital exploration of the ducts and of the pancreas was made. To close the normal gall bladder and leave it in the abdominal cavity and close the abdominal wound had been, in his experience, a dangerous proceeding, one causing the surgeon much anxiety. A colleague had reported to him a death occurring after this so-called ideal operation. A number of the surgeons at the Massachusetts General Hospital had a feeling of great distrust regarding immediate closure of the gall bladder, with or without closure of the external wound. One reason for this feeling was the tendency after suturing for hemorrhage to take place from the inverted edges of the mucous membrane, and by distending the gall bladder so to stretch the sutures as to allow of leakage of bile.

In some instances he had closed the gall bladder and fastened it to the wound in such a manner that if bile should escape it would come out through the external wound. So far as he knew, there had been no trouble from the insertion of gauze to guard against such accidents.

Biliary Fistula: In one or two instances biliary fistula had persisted. If bile escaped from the sinus and none was found in the stools it was clear that there was an obstruction of the common duct. Such a condition after an operation for gall stones, if associated with jaundice, pointed strongly to a stone left behind in the common duct. In one case of persistent biliary fistula the patient had been well so long as the bile had escaped, but as soon as the flow of bile had been obstructed she had become ill. She had not desired an operation, so she had been fed on ox gall and the bile allowed to escape. In cases of this kind in which the presence of a stone was doubtful this treatment seemed quite proper. Contamination of the operative field in ordinary operations on the gall bladder seemed to him not very likely to occur; it was quite different from operations on the appendix. In infections of the gall bladder the operation could be done without much danger of infecting the abdomen, no matter how bad the local infection might be.

Stones in the Ducts: When stones were impacted in the cystic duct they might be squeezed up into the gall bladder with the thumb and finger. Sometimes the stone would be so intimately adherent to the altered mucous membrane as to necessitate cutting down upon it and removing it piecemeal. He was not sure that it would not be well to remove the gall bladder in all cases in which it was necessary to incise a duct. In some instances the gall bladder would be apparently maligant. A thickened, adherent gall bladder containing stones should be removed, whether maligant or not. When the symptoms indicated obstruction in the common duct it was necessary to make a long incision. He had not found it necessary to cut across the rectus above, or deviate from the straight line below, as had been suggested. Digital exploration for maligant disease was sometimes misleading and unsatisfactory. When incision into the duct was made, great care should be taken that the large veins were not in the way. All incisions made around the foramen of Winslow should be made with the greatest intelligence and caution. While no doubt the hemorrhage could be checked by ligation of

the portal vein, the patient would die as a result of this ligation. By means of fine sutures a rent in the vein could be satisfactorily closed.

Hemorrhage: He had always been taught that it was dangerous to operate in cases of jaundice, yet he had learned to operate with great confidence in such cases, and had done so successfully for ten years. He had then operated upon what had appeared to be an exceptionally favorable case in every respect, yet the patient had died within twelve hours from a most extensive capillary hemorrhage. It was prudent to tie all points showing any tendency to bleed.

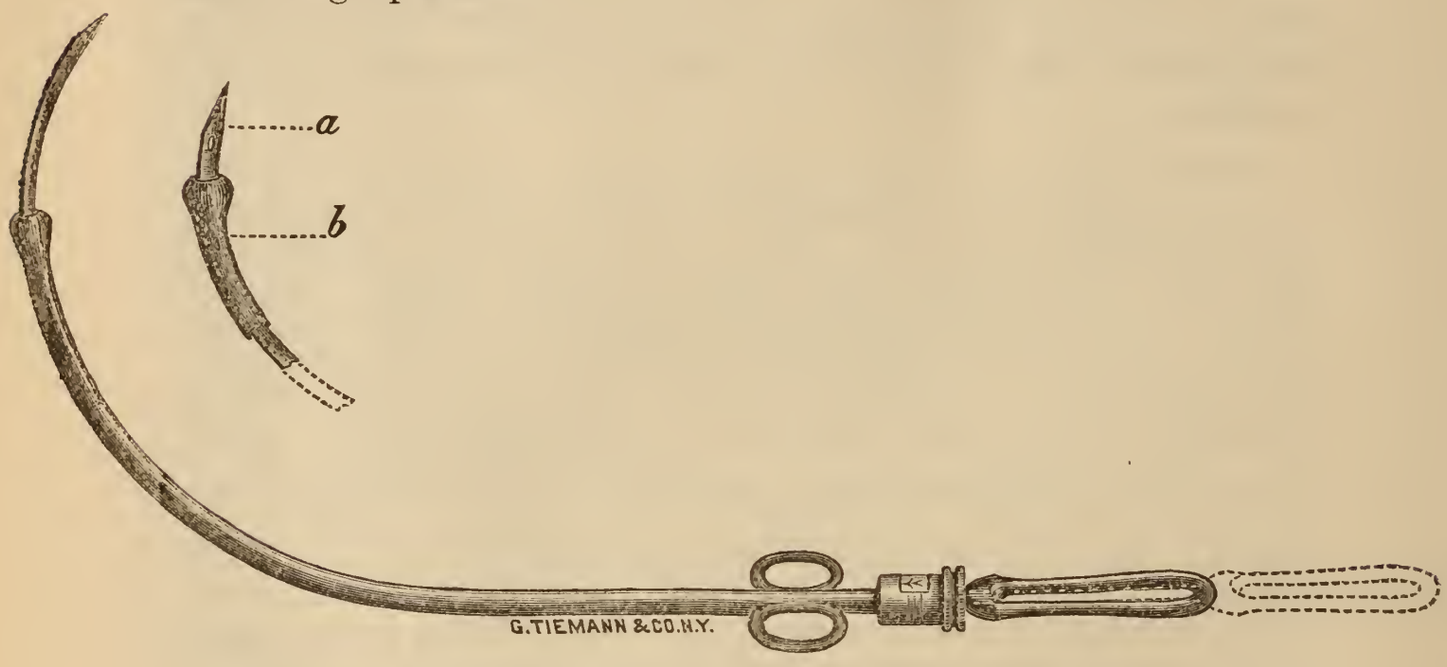
Experiments Performed at the Charity Hospital and Elsewhere with Sanarelli's Anti-amaryllic Serum in the Fall of 1898.—Archinard (*New Orleans Medical and Surgical Journal*, Aug. '99) reports in detail twelve cases treated and draws the following conclusions:

"From the above cases, which limit our experience with the anti-amaryllic serum of Sanarelli as a curative agent in the human being attacked with yellow fever, we are forced to conclude that this agent, in our hands, has shown no curative powers whatever, none of the important and dangerous symptoms of the disease having been in any way mitigated or prevented by its administration. Our hospital cases, it is true, were severe cases, and in some of them treatment was begun at so late a date as to preclude all hope. However, we have had cases enough, we believe, and the patient's symptoms before and after serum injection have shown so little change as to warrant our conclusions, as above expressed. In justice to Dr. Sanarelli, it must be said that he never pronounced himself as believing absolutely that his serum was curative in the graver cases; he cautions all users of the same, that the whole subject is still under study and recommends that the serum be used early. This latter instruction is not always easy to carry out, as a diagnosis cannot always be made early. Indeed, early in cases of yellow fever, it is difficult to say which are going to be severe and which are not, and judging by experience in this city in the last two years, the great majority of cases are benign and get well under any sort of treatment, and necessarily serum employed at random in these cases would be at a great advantage."

Experiments with rabbits showed that the serum had neither protective nor curative properties.

Ventral Fixation of the Uterus Without Laparotomy.—Suggs (*New York Med. Journal*, Dec. 9, '99) says that this may be readily done through the vagina if a suture carrier is used such as is here described and illustrated.

The posterior position is preferable, and Douglas' pouch is opened in the usual way. Uterine adhesions are broken up with the finger, and the ovaries and tubes are examined and treated as indications demand. With two fingers and a tenaculum the uterine fundus is then brought down backward through the opening in the vaginal vault. Two silkworm sutures are placed, preferably in the anterior uterine wall, and the surface scarified. Artery forceps catch the ends of the sutures and the fundus is pushed back into the peritoneal cavity. The patient should now be raised to Trendelenburg's position.



The carrier used is simply a long, curved canula, with a strong, flexible trocar that may be thrust out several inches beyond the bulb-pointed canula, and having an eye near the point for threading. The point is projected from the bulb, and the two ends of a long piece of medium silk are threaded in the eye and the point drawn back into the canula. This leaves a free loop hanging down by the instrument. Into this loop is placed one of the silkworm suture ends that are in the uterus and twisted.

The fingers are directed upward and forward through the vaginal incision toward the abdominal wall, which can be reached

when pressure from without is made. The bulb-ended suture carrier is introduced along in front of the fingers to the abdominal wall, and the needle is thrust through, carrying the silk with it, which is then unthreaded, and in its turn draws the silkworm through. The three other suture ends are in like manner drawn through, their proper or relative positions being maintained, and the opposite ones tied together over a small piece of gauze; the sutures remain in the usual time. The vaginal incision is closed with a few catgut sutures. In the presence of pus the fixation is contraindicated.

The Formative Period of Uterine Fibroids. — Murray (*Med. Record*, Dec. 2, 1899), from a careful study, offers the following suggestions in regard to the genesis of uterine fibroids:

1. The possibility of determining definite clinical symptoms which would lead to a recognition of a distinct formative period of uterine fibroids, which might suggest a preventive treatment.

2. That the predisposing causes of race, age (other than that of adult life), or condition count for little, and the elaborate reports which form the bulk of the literature up to the present time are of doubtful value.

3. That chronic inflammatory conditions of the endometrium, uterine parenchyma, and of the ovaries and tubes are most powerful predisposing causes, and that there is a direct relation between the hyperplasia of the uterus and the formation of fibro-myomata.

4. That extreme disturbances of the nervous system precede and accompany the formation of uterine fibroids. Insomnia, headaches, and hyperesthesia of the sensory organs are present to a greater degree than is usually fonnd when the concomitant symptoms of the inflammatory condition of the uterus are present.

5. That the evolution of the fibroid from fibro-myomatous centers when it begins to take on growth is exceedingly rapid, and that it is impossible to tell the age of the growth by its size. The rapid appearance and development are the reasons why so few fibroids are seen and examined in their incipiency. That the size and rapidity of growth of a fibroid depend upon its blood supply, which is determined from the beginning by the location of the nidus, and therefore such conditions as pregnancy or the menopause could have little influence.

6. The possibility of the action of curettage as a predisposing cause for these tumors on account of the violence done to the blood vessels, and of hastening their growth, because of concentrating the blood supply.

7. The crystallizing effect of Keiffer's experiments upon the theories in regard to the formation of fibro-myomata. He has demonstrated that the blood supply is cut off from the uterine tissue, which then becomes condensed into whorls of fibrillæ which afterward develop into fibroids, obtaining their blood supply from the surrounding uterine tissue. He has shown that the tumors were composed of an histological structure in no way differing from the normal uterine tissue, save that which related to the concentric arrangement of fibrillæ. There was no evidence of embryonic tissue or new formation.

The Pathogenesis of Appendicitis.—A. O. J. Kelly (*Phila. Med. Jour.*, November 25, 1899) says the factors that operate to render the appendix less resistant than other portions of the intestinal tract to the onslaughts of bacteria and other determining causes of inflammation are several. Of prime importance is the precarious blood supply of many appendices. The blood supply is defective not alone because of the manifest alterations frequently demonstrated in the walls of the blood vessels, but also because of the liability of the occurrence of partial or complete obstruction of the blood channels as a result of angulations, torsions, etc. Of importance in a limited number of cases is doubtless also alterations in the nerves supplying the appendix; but it is believed that they are not of such great importance as has been suggested by Fowler and Van Cott. Finally, in this connection the evidences of retrogression of the organ are not without significance. The factors that in the appendix give rise to increase in the virulence of bacteria normally present in the intestine are such as interfere with thorough drainage of the organ. Defective drainage may supervene when for any reason the appendix is so situated that it cannot be readily emptied; when its lumen is constricted either externally by bands of cicatricial connective tissue, tumor formations, etc., or by cicatrices of its walls, or by obstructions within its lumen, as, for instance, by fecal concretions or foreign bodies; or when the muscular coat of the organ is no longer capable of active peristalsis, as is likely

to be the case when the appendix is itself diseased or bound down by adhesions. Congestive disturbances of the appendix or of the cecum may cause such swelling of the mucous membrane as to lead to approximation of the apposed surfaces in the appendix, or occlusion of the outlet of the organ, and thus effectually prevent drainage. Of considerable significance with reference to this question of drainage in the etiology of appendicitis are certain of the anatomic and physiologic peculiarities of the organ above alluded to. Of these may be mentioned the size and shape of the meso-appendix, the excessive length as compared with the caliber of the lumen of the appendix, and Gerlach's valve. As further conducive to imperfect drainage are the already mentioned torsions and angulations, which interfere not alone with the blood supply, but also with thorough drainage. Fecal concretions are capable of at least a twofold action. They may not only occlude the lumen of the appendix, and effectually prevent drainage, but they may also by attrition, the result of constant or intermittent peristalsis, cause erosions of the mucous membrane, and thus reduce the power of the organ to resist the attacks of bacteria or their toxins. When of small size these concretions are doubtless often innocuous, but when they have attained a considerable size and are no longer capable of being extruded, they may engender the most diastrous results.

Palatable Quinin Mixture for Children.—Greanellé (*N. Y. Med. Jour.*, Oct. 28) says: Having had occasion to prescribe quinin repeatedly for young children, and being dissatisfied with the combination with syrupus yerbæ santæ, I have made a number of experiments with a view to obtaining a pleasant and acceptable quinin preparation which could be continuously administered to children without their objection.

I give below the details for the preparation of a "child's quinin mixture," which I find not only to be readily taken by children, but also serviceable as a bribe to be given after unpleasant medicines, such as stronger solution of quinin.

The mixture is designed as a tonic and malarial prophylactic for children living in malarious sections. It will serve for active medication in acute cases of malarial disease in children of 3 years or younger by giving the larger dose at hourly intervals.

I find that children literally cry for it, and that it has frequently

served as an excellent bribe, to be given immediately after a simple solution of quinin hydrochlorid in water when large doses of the drug are necessary. A teaspoonful of water carrying two or three grains of quinin muriate will be readily taken by any child, with a spoonful of "pink medicine" right after. Those who have little patients in large numbers will appreciate this.

(1) ℞ Quinin hydrochlorate gr. v–gr. x;
Alcohol ℥j.
M.

(2) ℞ Oil of cinnamon, } each *m* xxx–xl;
Oil of anise, }
Magnesia q. s.;
Water ℥j.
M. Let stand for some hours; filter.

(3) Mix 1 and 2 and add:
Simple syrup ℥iij;
Carmin or cochineal solution gtt. v.

Dose, one or two drams, as directed.

Saccharin in small quantity helps to disguise the larger dose of quinin.

Small doses of Fowler's solution may be added, if indicated, or sodium bromide for children made irritable by quinin.

Druggists will make this in quantity and keep it in stock if requested. It is simple, easily made, and inexpensive. Moreover, children like it.

The Importance of Early Diagnosis in Locomotor Ataxia as Affected by the Newer Pathology.—W. B. Pritchard (*N. Y. Med. Jour.*, July 22, 1899) says that the early diagnosis of tabes is of vital import as regards prognosis. Early symptoms are extremely varied.

Certain recent additions to the pathology of this disease caused him to write this paper. Formerly, it was supposed to be simply a sclerosis of the posterior columns of the cord. Waldeyer, through Golgi's stain, established the neurone as the nervous unit. Neurones include the cell, its nucleus, and all its processes as a unit. The neurone he considers is the one belonging to the posterior spinal ganglia and ganglia of the sensory cranial nerves. The oxone of this neurone divides into two branches, one of which passes to the periphery, the other to the cord. The fibers from the latter divide into three sets of fibers and pass up in the cord, some in the

posterior horn of the cord, some entering Clarke's and Goll's columns, some passing up entire length of cord through columns of Burdach's cord and ending in the medulla.

These neurones in the posterior ganglia are then the trophic centers for both the peripheral and posterior roots. They are very vulnerable to disease for various reasons, such as exposure, precarious blood supply, etc. In advanced disease we find degeneration in the columns of Lissauer, Goll, Clarke and Burdach.

Early symptoms are sensory and neurotrophic. Motor late. Syphilis, the great etiologic factor in tabes dorsalis, exerts its influence by inpairing nutrition, and since these neurones are vulnerable we have as a result of impaired nutrition a parenchymatous atrophy and not a syphilitic neoplastic growth. The short fibers of the dorsal roots are the first to yield, and then the medium and then the long fibers. This explains the so-called stationary periods. Secondarily a sclerosis follows this atrophy or neuritis.

Such is the newer pathology of locomotor ataxia. Assuming it to be true, what are the correlated deductions as to prognosis and treatment? Realizing the importance of diagnosing this condition before the period of secondary sclerosis, he mentions certain early symptoms.

Bear in mind age, sex, occupation, and syphilis. Any nervous disturbance in a man 30 to 45, who has had syphilis, if sensory, should lead to examination of knee jerk, pupils, and genito-urinary apparatus. Periodical vesperian headaches with insomnia in fore part of night. Unusual and excessive fatigue. Cachectic appearance. Disturbances of common sensation, such as defects in tactile, pain and muscular sense. The characteristic shooting pains are often the first symptom. May affect fifth nerve and teeth may be lost and hair become brittle.

Ocular symptoms: Strabismus and ptosis with diplopia occurring suddenly in a male adult means locomotor ataxia. Pupillary changes common early. Myosis. Argyll-Robertson loss of reaction to light.

Nerve atrophy is sometimes the primary symptom.

Romberg's symptom, inability to stand with eyes closed.

Genito-urinary symptoms: Sexual impotence dependent upon defective erection should excite suspicion. Defective sensibility of scrotum is a common early sign. Derangement of vesical function, slight incontinence or tardiness.

Reflexes: Loss of knee jerk. In cervical tabes knee jerk may be normal. Loss present in 92 per cent. of cases.

Trophic symptoms: Perforating ulcers. Sudden painless swelling of joints, arychia, herpes, bullæ, etc.

Crises: Gastric, enteric, laryngeal, bladder, rectal, may be the beginning of locomotor ataxia.

The Excretion of Uric Acid During an Attack of Gout.—Badt (*Zeitsch. F. klin. Med.*, Bd. 27, heft 5 and 6—*Am. Jour. Med. Sci.*, Nov., '99) "delivers another blow at the old and generally accepted teaching concerning the relation between uric acid excretion and gout. He reports the results of estimations of uric acid in five cases of gout—four estimations being made in each case: three of them during the acute attack, and the fourth some weeks later, in order to compare the conditions at the two periods. In no instance was the excretion found lessened during the attack; indeed it was usually greater than in the interval, though the increase was so slight as to be negligible. This is, of course, directly opposed to the old teaching that there is uric acid retention in the early part of the attack, and free excretion as the attack passes off; and the work is confirmatory of that done by other recent workers who have used accurate methods. Taylor's work (*Am. Jour. Med. Sci.*, August, '99) has shown very convincingly that in a healthy man the excretion of all the urine bodies is almost exactly parallel to the quantity contained in the food, a fact which has been generally overlooked in considering the amount excreted in attacks of gout. This is a matter of especial importance, as but small quantities of food are taken, as a rule, in the early part of the attacks, and as the intensity of the suffering and depression becomes less the patients take relatively larger amounts of food."

Non-Diabetic Glycosurias.—A distinction should be made between diabetes mellitus and glycosuria. Under the latter denomination should not be involved the many glycosurias occurring temporarily from increase of the physiologic amount of glucose in the blood, or from a transient disturbance, viz., malarial attack, epileptic seizure, strangulated hernia, cholera, anesthesia, asphyxia, intoxications (curare, carbon oxide, phlorizine, urane nitrate, nitro-benzine, etc.)—all conditions analogous to the experimentation of the

physiologist who in his laboratory can produce and arrest at will glycosuria.

Glycosuria of a more persistent character is that which is mistaken for diabetes mellitus; yet it should be differentiated from it. Diabetes mellitus is a clinical entity involving other symptoms than glycosuria. It can exist without glycosuria. In fact at the time glycosuria disappears in many cases of diabetes mellitus, the stage is one of aggravation, if not of fatal termination. All the symptoms in diabetes mellitus indicate severe nutrition changes and final disintegration.

The lasting glycosurias spoken of here, not due to the diabetic condition, have a common feature which serves to distinguish them as a class; they are symptomatic, and they may be divided in the following manner upon the study of these etiologic factors:

1. Intermittent glycosuria in arthritics:
   - *a* Hereditary arthritic glycosuria in young subjects.
   - *b* Gouty glycosuria in adults and old age.
   - *c* Glycosuria in obesity.
   - *d* Azoturic glycosuria.
2. Digestive glycosurias:
   - *a* From excessive alimentation with sweet and starchy food.
   - *b* From disturbances of digestion.
3. Nervous glycosurias:
   - *a* In systematic affections of the nervous system (brain, bulb, medulla and nerves.
   - *b* In neuroses and psychoses.
   - *c* Traumatic glycosuria.
   - *d* Puerperal glycosuria.

Les Glycosuries non Diabetiques par Germain Roque, 1899.

Some Clinical Observations in Rectal Diseases. — Sherwood-Dunn (*Jour. Amer. Med. Assn.*, Nov. 11, '99) refers in his paper to some cases of pruritus ani, the most obstinate of which was due to small superficial ulcers between the internal and external sphincters, showing on the posterior surface, but which may be also found on the anterior surface of the gut, and in the latter situation is very likely to be unnoticed; he calls it "simple ulcer of the rectum" and says it needs to be looked for carefully. Care is necessary in using

the speculum, as this will displace tissues upward and turn the surface away from the operator; its livid purple color and rough surface are points to aid in its discovery. In office practice he treats them by first applying cocain, then cauterizing with lactic acid, pure; the surplus is wiped away, and the patient directed to inject, twice daily if possible, after evacuation, two ounces of 25 per cent. peroxid of hydrogen. Two cases are related, one of which developed double ischio-rectal abscesses and was curetted, when, upon examination there was a very small ulcer as the cause of the trouble. The other was a woman who had been treated for a month for pruritus, that had a large ischio-rectal abscess from an opening in the bowel fully six inches up. Another case is reported that recovered from a sinus operation in sixteen days.

Epidemic Cerebro-Spinal Meningitis and Lumbar Puncture.—Dr. J. L. Hirsch (*N. Y. Med. Jour.*, August 19) says: As to the therapeutic value of lumbar puncture all do not agree. By relieving abnormal pressure, and probably by getting rid of some of the toxins, the beneficial results can readily be conceived. The technique of the operation is simple and the pain to the patient is but slight. In children I have found the best position to be with the child lying on its right side and its back slightly arched, so that the spinous processes stand out prominently. Many prefer the child in the sitting position. The puncture is to be made between the second and third, or the third and fourth, lumbar vertebræ. The needle, from 5 to 8 cm. long, is thrust in about 1 to 2 mm. from the median line, so as to avoid the strong intra-spinous ligament. When the needle is within the spinal canal its point can be felt to move freely; if the fluid does not flow spontaneously, slight suction may be made with a hypodermic syringe. Needless to add that all antiseptic precautions must be observed. A procedure so simple, so readily carried out, and so absolutely devoid of danger, has no contraindications for diagnostic, if not for therapeutical purposes.

BOOK REVIEWS.

Any medical book can be obtained through the Lancet at publisher's prices, postage free. Terms cash. The usual discounts are allowed.

An American Textbook of Surgery for Practitioners and Students. By Phineas S. Connor, M.D., Frederick S. Dennis, M.D., William W. Keen, M.D., Charles B. Nancrede, M.D., Roswell Park, M.D., Lewis S. Pilcher, M.D., Nicholas Senn, M.D., Francis J. Sheppard, M.D., Lewis A. Stimson, M.D., J. Collins Warren, M.D., and J. William White, M.D. Edited by William W. Keen, M.D., LL.D., and J. William White, M.D., PH.D. Third edition, thoroughly revised. Philadelphia: W. B. Saunders, 925 Walnut street, 1899. Price, cloth, $7; sheep, $8, net.

The third edition of this valuable and standard textbook brings it entirely up-to-date. Its popularity and worthiness is evidenced by the fact that it is used as a textbook in over 100 medical colleges in this country. To a book, which since its first edition, in 1892, has been recognized as authoritative, we can safely give our commendation. New topics have been introduced, such as the use of dry heat at high temperatures, serum therapy, surgery of typhoid fever, operations on stomach, surgery of ureters, rubber gloves, etc., etc. The sections on Appendicitis, Fractures and Gynecological Operations have been enlarged and revised. A number of new illustrations have been added, one of which, a colored plate showing several specimens of appendicitis, is very beautiful. This book combines cheapness with completeness, giving as it does the whole subject of Surgery under one cover.

Progressive Medicine. A Quarterly Digest of Advances, Discoveries and Improvements in the Medical and Surgical Sciences. Edited by Hobart Amory Hare, M.D., etc. Volume III, September, 1899. Diseases of the Thorax and its Viscera, including the Heart, Lungs and Blood Vessels; Diseases of the Skin; Diseases of the Nervous System; Obstetrics. Lea Brothers & Co., Philadelphia and New York: 1899.

This is the third of the series of Lea's quarterly, and up to the standard of its predecessors. The first part is under the charge of William Ewart, M.D., F.R.C.P. He regards finger percussion upon a pleximeter as the most delicate method. Other means of physical examination are discussed, including Litten's sign, the Roentgen ray, and bronchoscopy. This department covers 151 pages and cites 342 references. Diseases of the pleura, air passages, lungs, of the esophagus, blood vessels and heart are considered. The diseases of the skin, by Henry W. Stelwagon, cover 100 pages and a rich bibliographic reference. We find a quotation from Tuttle, to the effect that X-ray burns so far reported have been from the use of the induction coil, and never from the static machine. This department contains 11 photographic reproductions, the only illustrations in the book. The diseases of the nervous system, by Wm. G. Spiller, contains, in 70 pages, very numerous brief excerpts from the literature of the past year. The subject matter is very varied. The balance of the volume is on the progress of obstetrics, by Rich. C. Norris. It is presented under the following heads: Pregnancy, extra-uterine pregnancy, eclampsia, the surgery of obstetrics, accidents in labor, the puerperium, puerperal complications, and lactation. The subject matter is handled rather editorially.

A Textbook of Embryology for Students of Medicine. By John Clement Heisler M.D., Professor of Anatomy in Medico-Chirurgical College, Philadelphia. With 190 illustrations, 26 of them in colors. Philadelphia: W. B. Saunders, 1899. Price, $2.50, net.

The book is especially designed for anatomy students, and occupies a middle ground between compends and the very exhaustive scientific works now extant. It covers the ground as completely as the ordinary medical student can possibly need. The style is lucid and free from prolixity, and controversial matters are decided, with due conservatism, in favor of the latest teaching. The illustrations are well chosen and the typography is up to the standard for which this house is famous. There is no bibliographic reference and no list of illustrations. The reading matter covers 390 pages, which include a very useful chronologic table, reference to which will tell at a glance what each tissue is doing at any period of development. The book is not intended for laboratory work.

Annual and Analytical Cyclopedia of Practical Medicine. By Charles E. de M. Sajous, M.D., and One Hundred Associate Editors, assisted by Corresponding Editors. Collaborators, and Correspondents. Illustrated with Chromo-Lithographs, Engravings and Maps. Volume IV. Philadelphia, New York, Chicago: The F. A. Davis Co., 1899.

We have already expressed our admiration for this excellent work, a feeling which the present volume does much to strengthen. Conspicuous among the articles composing this volume are those on "Diarrheal Diseases of Infants," by Professor Blackader, of Montreal, and the one on "Malarial Fever," by Professor J. C. Wilson and Dr. Thos. G. Ashton, of Philadelphia, the latter being particularly elaborate. The volume is uniform with its predecessors, and in appearance reflects as much credit on its publishers as its contents do on the editor and his assistants.

The Surgical Diseases of the Genito-Urinary Tract, Venereal and Sexual Diseases. A Textbook for Students and Practitioners. By G. Frank Lydston, M.D., Professor of the Surgical Diseases of the Genito-Urinary Organs and Syphilology in the State University of Illinois (the Chicago College of Physicians and Surgeons); Professor of Criminal Anthropology in the Kent College of Law; Surgeon-in-Chief to the Genito-Urinary Department of the West-Side Dispensary; Late Major and Surgeon U. S. V.; Fellow of the Chicago Academy of Medicine; Fellow of the American Academy of Political and Social Science; Delegate from the United States to the International Congress for the Prevention of Syphilis and the Venereal Diseases, held at Brussels, Belgium, September 5, 1899; etc. Illustrated with 235 engravings. Philadelphia, New York, Chicago: The F. A. Davis Company, publishers, 1899. Price, cloth, $5.

This book contains 1000 pages, and is composed of ten parts respectively: Part I. General Principles of Genito-Urinary, Sexual and Venereal Pathology and Therapeutics. Part II. Non-Venereal Diseases of the Penis. Part III. Diseases of the Urethra and Gonorrhea. Part IV. Chancroid and Bubo, and their Complications. Part V. Syphilis. Part VI. Diseases Affecting Sexual Physiology. Part VII. Diseases of the Prostate and Seminal Vesicles. Part VIII. Diseases of the Urinary Bladder. Part IX. Surgical Affections of the Kidney and Ureter. Part X. Diseases of the Testis and Spermatic Cord. A careful survey of the above brings us to the conclusion that the various subjects of genito-urinary, venereal and sexual diseases are all mentioned. The views of the author as to the specificity of the gonococcus not being adequately proven, are at variance with our own, as we believe that all cases of specific urethritis are due to

gonococci. The plan of treatment of acute urethritis deserves special commendation for its simplicity, conservatism and thorough consideration of all remedies. The chapters on syphilis are very complete and modern. The illustrations are good, type plain, price moderate, and the book is one of the most complete on these subjects we have seen.

Notes on the Modern Treatment of Fractures. By John B. Roberts, A.M., M.D., Professor of Surgery in the Philadelphia Polyclinic; Mutter Lecturer on Surgical Pathology of the College of Physicians of Philadelphia. With 39 illustrations. New York: D. Appleton & Co., 1899. Price $1.50.

In the short preface the author, for whom we have the greatest respect, says: "No injuries require more careful and judicious treatment than fractures; and in no branch of surgical therapeutics is the exercise of common sense followed by more satisfactory results." In the pages that follow he clearly demonstrates these facts; for example, he reports a series of forty-three Colles fractures treated in a period covering three months in the simplest possible way, but with the very best results. He calls attention to the fact, in a very cursory way, that in this antiseptic and aseptic era compound fractures often do better than simple fractures, so far as deformity is concerned, for the reason that in compound fracture the surgeon can deal directly with the deformity by the aid of sight and touch, thereby getting better apposition, better union, and consequently less shortening. He therefore does not hesitate to cut down upon the seat of fractures, in selected cases, and wire, nail and rivet the broken ends of the bones, his preference being wire nails. We are glad to learn that in this the author confirms the views of Warbasse, who, in a series of many hundred cases of fractures, found the direct method of treatment the best. The author also gives tenotomy a prominent place in the preliminary treatment of fractures, making particular reference to subcutaneous tenotomy of the tendon of Achilles and the quadriceps extensor. He also advocates, but in a half-hearted way compared with most of his other teachings, direct suture of the fractured patella, confessing at the same time that he has but rarely been compelled to resort to this procedure. This does not altogether harmonize with his other statements *regarding direct treatment, safer and quicker convalescence, etc.* It is somewhat refreshing to note the manner in which the author deals with the question of retention apparatus. *The simplest is the best* is what he practically says, and by way of illustration shows on page 36 Bardenheure's dressing for an ordinary fracture for the lower end of the radius, in which the patient is confined to bed and surrounded by complicated pulleys, which pull in five different directions. Comparing this illustration with the one on page 43, where the same fracture, after proper reduction, this being the main consideration, is shown treated by a simple wristlet of adhesive plaster, the Bardenheure pulleys look ridiculously out of place, and we are witness to the most excellent results under the simpler treatment in the author's hands. The author pay his respects to the question of passive motion in the after-treatment of fractures as follows: "If the joint is involved in the line of fracture passive motion at an early stage will not prevent anchylosis, but may increase it by causing a greater degree of arthritis; if the joint is not involved by the fracture line early passive motion is not needed." The subsequent passages on this important point are of the greatest possible benefit to the student and young practitioner, and it is to these that we particularly commend the book. The X-ray is not forgotten as a diagnostic aid, and as an aid in the reduction of deformities, and several very interesting shadowgraphs are depicted. The book is short, readable and well printed, and after carefully reading it we can heartily recommend it.

BOOKS AND PAMPHLETS RECEIVED.

The Physician's Visiting List (Linsay & Blakiston's) for 1900. Forty-ninth year of its publication. Philadelphia: P. Blakiston's Son & Co. Sold by all booksellers and druggists.

Notes on the Modern Treatment of Fractures. By John B. Roberts, A.M., M.D., Professor of Surgery in the Philadelphia Polyclinic: Mutter Lecturer on Surgical Pathology of the College of Physicians of Philadelphia. With thirty-nine illustrations. New York. D. Appleton & Co., 1899.

Annual and Analytical Cyclopedia of Practical Medicine. By Charles E. de M. Sajous, M.D., and one hundred associate editors, assisted by corresponding editors, collaborators and correspondents. Illustrated with chromo-lithographs, engravings and maps. Volume IV. Philadelphia, New York, Chicago. The F. A. Davis Co., 1899.

An Atlas of the Bacteria Pathogenic in Man, with Descriptions of their Morphology and Modes of Microscopic Examination. By Samuel G. Shattock, F.R.C.S., Joint Lecturer on Pathology and Bacteriology, St. Thomas' Medical School, London; Pathologic Curator of the Museum of the Royal College of Surgeons, London. With an Introductory Chapter on Bacteriology; Its Practical Value to the General Practitioner. By W. Wayne Babcock, M.D., Pathologist to the Kensington Hospital for Women; Clinical Pathologist to the Medico-Chirurgical Hospital; Demonstrator of Pathology and Bacteriology in the Medico-Chirurgical College of Philadelphia. Sixteen full-page colored plates. E. B. Treat & Co., New York. 1899. Price $1.

The Surgical Diseases of the Genito-Urinary Tract, Venereal and Sexual Diseases. A Textbook for Students and Practitioners. By G. Frank Lydston, M.D., Professor of the Surgical Diseases of the Genito-Urinary Organs and Syphilology in the Medical Department of the State University of Illinois; Professor of Criminal Anthropology in the Kent College of Law; Surgeon-in-chief of the Genito-Urinary Department of the West Side Dispensary; Fellow of the Chicago Academy of Medicine; Fellow of the American Academy of Political and Social Science; Delegate from the United

States to the International Congress for the Prevention of Syphilis and the Venereal Diseases, held at Brussels, Belgium, Sept. 5, '99, etc. Illustrated with 233 engravings 6½ by 9¾ inches. Pages xvi–1024. Extra cloth, $5 net; sheep or half Russia, $5.75 net. The F. A. Davis Co., Philadelphia.

A Textbook of Materia Medica, Therapeutics and Pharmacology. By George Frank Butler, PH.G., M.D., Professor of Materia Medica and Clinical Medicine in the College of Physicians and Surgeons, Medical Department of the University of Illinois; Professor of General Medicine and Diseases of the Digestive System, Chicago Clinical School; Attending Physician to Cook County Hospital; Member of the American Medical Association, Illinois State Medical Society, Chicago Medical Society, Chicago Pathological Society, and Chicago Society of Internal Medicine; Fellow of the Chicago Academy of Medicine, etc. Third edition, thoroughly revised. Philadelphia. W. B. Saunders. 1899.

NEWS AND NOTES.

THE publishing house of J. B. Lippincott & Co., Philadelphia, was recently destroyed by fire.

DR. R. H. MITCHELL has withdrawn from the firm of Mitchell & Maury, and has an office in the Southern Express Building.

DR. J. M. FOSTER, Professor of Otology in the University of Denver, spent the month of December in Memphis. He was the guest of the Memphis Medical Society at its annual banquet.

DR. WADE J. LANE has resigned his position as medical referee of the Equitable Life Assurance Society, and will leave for Marshall, Texas, where he will resume practice early in January.

SURGEON G. M. MAGRUDER has been relieved from duty at the U. S. Marine Hospital, Memphis, and ordered to London to study the plague. He was succeeded by Asst. Surgeon D. E. Robinson.

DR. ALLISON BROWN, who has been Dr. B. G. Henning's assistant for two years, will open an office in the Randolph Building on January 1st. Dr. Bruce Harkness will be with Dr. Henning after that time.

Dr. Geo. E. Pettey is contemplating opening a sanatorium in Memphis for the treatment of the whisky and drug habits. We are sure that he will be welcomed, as his treatment is scientific and his methods strictly ethical, and we may add, very successful.

The following officers have been elected by the Memphis Medical Society for 1900:

President—Dr. E. C. Ellett.
Vice-President—Dr. E. A. Neely.
Secretary and Treasurer—Dr. Edwin Williams.
Reporter—Dr. Richmond McKinney.

Suit has been brought by the heirs of Mrs. Nancy E. Taylor of Thornport, O., against Dr. J. F. Baldwin of Columbus for $10,000 damages, the allegations being that he caused the death of Mrs. Taylor. Mrs. Taylor died from blood poisoning after an operation performed at the Protestant Hospital by Dr. Baldwin. A post-mortem examination showed that a cheesecloth sponge had not been removed from the woman's body after the operation. This sponge was shown to have been the cause of death. This was freely admitted by Dr. Baldwin and the hospital authorities. Dr. Baldwin laid the blame upon the nurse who assisted him with the operation, and in a series of published letters declares he asked the nurse if all the sponges were accounted for, and she answered "yes."

The Thirteenth International Medical Congress will be held in Paris from the 2nd to 9th of August, 1900, in connection with the French Exposition. All Doctors of Medicine are entitled to membership in this Congress by making the proper application and paying the sum of $5.00. The Secretary-General in Paris has instructed the American National Committee to receive the applications of American physicians, and the Committee hopes the American representation in this extremely important Medical Congress may be as large as possible, and they would urge every member of the profession to enter his name for membership, this alone entitling him to receive a digest of the full proceedings of the Congress and the printed report of the section to which he belongs. Dr. Henry Barton Jacobs, 3 W. Franklin St., Baltimore, is the secretary of the American Committee.

A decision of considerable importance has been made by Judge Kohlsaat in the United States Circuit Court. In a bill for an

injunction Fairchild Brothers & Foster of New York had charged Edward Otto, a Chicago druggist, with substituting a spurious and inferior preparation for "Fairchild's Essence of Pepsine," where the latter was expressly called for in physicians' prescriptions. Judge Kohlsaat's decree sustains the charges made, perpetually enjoins Otto from ever repeating the offense, and taxes him with the costs, amounting to about $500. This is said to be the first contested case in the United States in which the principle of protection to trade marks and trade names was extended so as to apply to what is technically known in the drug business as "substitution." Judge Kohlsaat's decision will probably protect manufacturing chemists, physicians and the general public, all of whom have in the past suffered from these fraudulent practices of a certain class of druggists.

The first Annual Banquet of the Memphis Medical Society was held at the Cordova Hotel on December 19th. Thirty members attended, and the evening was most pleasantly spent. The following toasts were given:

"Our Profession"—Dr. E. C. Ellett.
"Fraternal Relations"—Dr. Heber Jones.
"Kitchen Physic"—Dr. B. G. Henning.
"The Old Doctor"—Dr. D. D. Saunders.
"The Young Doctor"—Dr. Richmond McKinney.
"Ye Specialist"—Dr. F. S. Raymond.
"Wives and Sweethearts"—Dr. N. F. Raines.
"Fraternal Relations"—Dr. E. P. Sale.
"Denver"—Dr. J. M. Foster.
"Our New Officers"—Dr. E. A. Neely.
"The Memphis Medical Society"—Dr. B. F. Turner.

The health, long life and happiness of Dr. D. D. Saunders was proposed, to which Dr. Saunders made a touching response.

The following ordinance is self-explanatory:

SMALLPOX ORDINANCE.

Section 1. Be it ordained by the Legislative Council of the City of Memphis, That the Board of Health of the city is hereby empowered to declare, by resolution, when any houses, blocks or districts in the city, or within one mile thereof, are infected with smallpox contagion or liable to become so infected, and to set forth in such resolution the location of such houses and the boundaries of such blocks and districts.

Section 2. Be it further ordained, That when such resolution is passed by the Board of Health it shall be the duty of all persons residing in the houses, blocks or

districts, so designated in said resolution, who have not been successfully vaccinated, to cause themselves to be vaccinated at once, and to provide themselves with the certificate of a reliable physician that said person has been successfully vaccinated, and the date thereof, or that such person has been so often and carefully vaccinated as to prove further vaccination unnecessary; and said certificate shall be produced when called for by any officer of the health or police departments; and all parents or guardians of children residing or found within such house, block or district shall cause their children or wards to be vaccinated.

Any person residing, or found, within any house, block or district declared by the Board of Health to be infected, or subject to infection, and who, at the expiration of five days after the passage of said resolution, shall have failed to be vaccinated, shall be guilty of a misdemeanor, and fined not less than two dollars nor more than fifty dollars for each offense. And, furthermore, said person shall submit to compulsory vaccination by any health officer or physician designated for that purpose by the President of the Board of Health, and all children shall be subject to compulsory vaccination.

And any person who refuses to be vaccinated as herein required, or resists compulsory vaccination, shall be guilty of a misdemeanor, and shall be fined not less than two dollars nor more than fifty dollars for each offense.

Passed third and final reading December 7, 1899.

Attest: W. B. ARMOUR, Secretary. J. J. WILLIAMS, Mayor.

THE Semi-Annual Meeting of the West Tennessee Medical and Surgical Association was held at Milan, Tenn., Thursday and Friday, Dec. 14 and 15, 1899. The following program was presented:

1. Fractures of Lower Extremities—Jere L. Crook, M.D., Jackson.
2. Colles Fracture—W. S. A. Castles, M.D., Oakland.
3. Static Electricity in the Treatment of Diseases—Wm. T. Watson, M.D., Lexington.
4. Acute Bronchitis in Children—J. R. Nelson, M.D., Eurekaton.
5. Pseudo Cyesis—Alfred Moore, M.D., Memphis.
6. Atypical Typhoid Fever (so-called)—J. H. Reilly, M.D., Memphis.
7. Differential Diagnosis of Eruptive Fevers—T. J. Happel, M.D., Trenton.
8. Small Pox—F. S. Raymond, M D., Memphis.
9. Treatment of Valvular Les ons of the Heart—Frank A. Jones, M.D., Memphis.
10. Empyema—A. E. Cox, M.D., Milan.
11. Exhibition of Specimens with Remarks—E. C. Ellett, M.D., Memphis.
12. Abscess of the Liver with Report of Case—M. Goltman, M.D., Memphis.
13. Public Education in Regard to the Care of the Teeth—M. M. Haltom, D.D.S., Paris.
14. Reports of Cases—T. J. Crofford, M D., Memphis.
15. Correction of Deviated Septum—Richmond McKinney, M.D., Memphis.
16. Senile Pneumonia—J. S. Rawlings, M.D., Dancyville.

NO OTHER SERUM German, French or American. . .

Has Ever Yielded Such High Percentages of Recovery.

CHICAGO MORTALITY

4.78 per cent.

In Chicago during the months of November and December, 1898, and January and February, 1899, there were treated with Parke, Davis & Co.'s Antidiphtheritic Serum by the Antitoxin Staff of the Chicago Health Department 418 cases (microscopically verified), with 20 deaths—a mortality of 4.78 per cent.

DENVER MORTALITY

3.5 per cent.

In Denver during 1898 there were treated with Parke, Davis & Co.'s Antidiphtheritic Serum 230 cases, with 8 deaths —a mortality of 3.5 per cent.

PARKE, DAVIS & COMPANY,

Home Offices and Laboratories, Detroit, Michigan.

Branches in New York, Kansas City, Baltimore, New Orleans, and Montreal, Quebec.
Branch Laboratories, London, Eng., and Walkerville, Ont.

CLINICAL NOTES.

A Contribution to the Therapeutics of Pepto-Mangan, "Gude." Dr. Ludwig Pohl (*Aerztlicher Central Anzeiger*, Vienna, Austria, Sept. 20, 1899) writes:

It is about five years ago that I first had occasion to test Gude's Pepto-Mangan. The curative results obtained from its use were so surprisingly good that I decided to thoroughly experiment with this preparation on my abundant clinical material, the outcome of which is reported in this article.

The number of remedies introduced every year into the market is so great that for this reason alone it would be impossible to employ all of them, even if only experimentally, or to make a careful choice. Pepto-Mangan appealed to me strongly in the first instance for reasons that I shall explain. Although inclined to think well of this preparation from the first, I would remark that my observations were instituted without bias, and that my investigations were carried out in a strictly scientific manner.

I was led to make a thorough study of this preparation by the subjective statements of the patients that it never caused the least disturbance, the objective evidences of improvement, and, besides these, by the following considerations:

According to the views of many authors, iron preparations, to be efficient, must exert not only a local but distant, that is, general effect. In chlorosis and in many severe cases of anemia chalybeates are said to remove the hydrogen sulphide, formed frequently in large amount in the alimenary tract, by the combination of the iron with the sulphur. This removal is necessary, because hydrogen sulphide, if present in too large quantity, renders impossible the absorption of the iron in the food by precipitating it in the form of sulphide of iron. It is known, however, that not only iron but also manganese is adapted in a high degree for taking up hydrogen sulphide. Manganese therefore acts as an auxiliary to iron in this respect.

Another circumstance was decisive to me. A large number, almost all, of the officinal ferruginous preparations are absorbed only to a slight extent when administered internally. This can be maintained on the ground of the fact, that in animals and human beings positive evidence of the entrance of these preparations into the blood cannot be obtained if the persons experimented with have

not intestinal catarrh or have not received excessive doses of iron. The more the preparation approximates to the form in which iron is contained in the food, the more likely it is to be absorbed. The peptonizing of an iron preparation is therefore of decided advantage, as its absorbability and assimilability is thereby enhanced to a considerable degree. Aside from this, the peptone combination is adapted for exerting the systemic effect. This general action of iron preparations only takes place if after absorption they undergo conversion into hemoglobin. Hence this conversion is only possible in the case of preparations which contain iron in form of an organic combination. They will then act even when containing a much smaller percentage of absolute iron.

It was therefore the chemical constitution of the preparation which appealed to me, and which induced me to undertake extensive experiments.

The cases in which I employed Gude's Pepto-Mangan comprised chiefly the poorer class of people. I mention this particularly, because with these patients it is difficult or well nigh impossible to pay attention to the hygienic conditions or to consider the dietetic side of the treatment. Notwithstanding this, the results were favorable. Of course, they were most satisfactory in the cases of those patients who were able to carry out the hygienic and dietetic regulations.

Numerous cases of chlorosis, anemia, neurasthenia, and hysteria, as well as two cases of malarial cachexia, were submitted to careful and thorough observation.

In many cases determinations of the bodily weight, measurements of the blood pressure, estimates of the hemoglobin percentage, and blood counts were made.

As regards the bodily weight, I observed in sluggish, obese, chlorotic patients a reduction in flesh as well as improvement of the general state. The high absorbing power of the preparation and its ready conversion into hemoglobin increases the oxygen capacity of the blood; *pari passu* with this there is an improvement of the metabolism, the oxidation, which takes place at the expense of the non-nitrogenous elements of the body, that is, the adipose tissue. In the case of lean persons I combine with this treatment rest in bed for several weeks, to which may be ascribed the increase of bodily weight observed.

There was a constant change in the conditions of blood pressure. In almost all the chlorotic patients the blood pressure, estimated by Basch's sphygmomanometer, became considerably higher. In many of my cases I noted improvements in the blood pressure of

40 to 60 millimetres in the course of four weeks. Besides this, the fluctuations of blood pressure, so frequently observed during changes of position, disappeared; the pulse frequency diminished considerably; and the subjective disturbances connected with the circulatory apparatus, especially the troublesome palpitation of the heart, subsided. I would remark that this amelioration occurred under the use of no other remedy in so short a time as under that of Pepto-Mangan.

In judging of the value of an iron preparation, conclusive evidence is afforded by estimates of hemoglobin and blood counts. To determine the hemoglobin I employed Fleischl's hemoglobinometer, and as a solvent a 0.6 per cent. sodium chloride solution; for blood counts I made use of the apparatus of Thoma-Zeiss and a 2.5 per cent. solution of potassium bichromate for the red blood corpuscles; the white were not counted.

To demonstrate the changes in the hemoglobin and in the number of red corpuscles, I report here the history of a girl, 16 years old, affected with marked chlorosis. The disease was of almost two months' duration and attended with general functional disturbance. There were present mental anxiety, a disinclination to work, to enjoy life, or move about, marked muscular weakness, cardiac palpitation, difficulty in breathing, loss of appetite, headache, vertigo, restless sleep alternating with sleeplessness. The patient came from healthy parents, had previously been always healthy, and menstruated for the first time in her fifteenth year, but scantily and irregularly. Marked pallor of the skin and mucous membranes was noted; the lungs were normal. The area of cardiac dullness was enlarged toward the right side; blowing murmurs were heard over all the valves, and a bruit over the jugular vein. The radial artery was very small and soft; the pulse frequency 110. The spleen and liver were normal in size; there were no glandular swellings; the bones were not tender to pressure. The urine contained no abnormal constituents.

The percentage of hemoglobin in the blood was 35 per cent.; the number of red blood cells, 2,700,000 to the cubic millimetre. The white cells were not increased; otherwise the condition of the blood was normal.

The treatment was as follows: The patient was advised to live on a mixed diet, with an abundance of fresh air and moderate outdoor exercise. She also took three teaspoonfuls of Pepto-Mangan daily.

The increase of hemoglobin and of the number of red corpuscles is shown in the following:

At end of 1st week,	Hemoglobin,	45	per cent.,	Red Corpuscles,	3,260,000	}	
" " 2d "	"	60	"	"	4,100,000	}	To the Cubic
" " 3d "	"	70	"	"	4,500,000	}	Millimetre.
" " 4th "	"	75	"	"	4,900,000	}	

Before proceeding with the history of this case I would emphasize the fact that the number of red blood cells increased more than one and one-half million, while the increase of hemoglobin amounted to more than 100 per cent. Such marked improvement in the condition of the blood under the treatment with Gude's Pepto-Mangan was not unusual, but rather the rule in chlorosis. And it may be assumed with certainty that the above described effect is attributable to the high absorbability of this preparation as compared with the numerous other chalybeates, and further, to the combined action of iron and manganese upon the blood-forming organs. I would add that numerous investigators, such as Hannan, Kugler, and many other authors, have called attention to the important part played by manganese both in the blood and as a hematogenic remedy.

In the case under consideration there was a perceptible improvement in the patient's subjective and objective state. The existing disturbances subsided gradually; the cardiac palpation, loss of appetite and sleeplessness disappeared, and after four weeks' treatment she was discharged cured.

It is not the purpose of this report to detail numerous histories of cases, and I shall content myself with briefly mentioning that I have treated more than 100 cases of chlorosis with Gude's Pepto-Mangan with as good results as those above described, except that in some instances the results did not appear as promptly. The fact cannot be sufficiently emphasized that during the entire course of treatment the remedy did not have to be discontinued on a single occasion, although this must be often done with other ferruginous preparations. I never heard a complaint that the preparation was not well tolerated; on the contrary, the patients stated that they did not experience the slightest disturbance even during its prolonged use, and that it acted mildly, was well borne, caused no disturbance of digestion, but rather promoted the latter, and was free from any disagreeable taste.

I have previously mentioned that it may be positively assumed that Pepto-Mangan stimulates the hematopoietic organs to increased activity. Numerous blood findings discovered casually by me, the appearance of the so-called immature forms of blood corpuscles, constrain me to take this view. Of much greater importance is the circumstance, however, that in numerous diseases of the blood occurring in connection with the lymphatic and blood-making organs I have derived excellent results from Gude's Pepto-Mangan.

Decided amelioration in the leukemic state, arrest of the process in severe cases for a long time, reduction of the glandular swellings, improvement in the relation between the red and white corpuscles, were noted by me in several cases under my care.

In my opinion, the value of ferruginous preparations in neurasthenia and hysteria has received too little consideration. The success of a rational therapy depends upon an effective application of all methods of treatment and remedies which enable us to combat the entire group of symptoms. An easily absorbable ferruginous preparation is of incontestable benefit, and I believe that Gude's Pepto-Mangan occupies a prominent place in this connection. It is not my intention here to institute comparisons with various iron preparations. I would emphasize, however, for reasons already mentioned and which are especially based upon the composition of Gude's Pepto-Mangan, that I prefer the latter preparation, and have employed it successfully in all conditions where it is necessary to improve the quality of the blood.

In conclusion, I would mention that I have obtained excellent results from Gude's Pepto-Mangan in two cases of severe malarial cachexia. In the one case the treatment occupied three weeks, in the other five weeks. Both cases were cured. *It is of interest that in the first case, in which a malarial attack had not occurred for some time, a typical paroxysm with rigor, fever and sweats developed after one week's treatment. The attack failed to recur, and for this reason I was unable to search for plasmodia.* I am not disposed to overestimate this occurrence, nor to make it the subject of theoretical reflections. I am decidedly of the opinion, however, that this attack is attributable to an influence of Pepto-Mangan upon the spleen.

In all particulars Pepto-Mangan is an excellent preparation, which bids fair to occupy a permanent place in the materia medica. I would be pleased if through this article I had directed attention to this valuable remedy, and incited others to undertake experiments and report their observations.

GEO. E. PETTEY, M.D.

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Memphis, Tenn.

PRACTICE LIMITED TO TREATMENT OF THE

WHISKEY and DRUG HABITS.

Treatment is entirely harmless, comparatively painless, and the time required is short.

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Trophonine

a palatable and nutritious liquid food, contains the nutritive elements of beef, egg albumen and wheat gluten, so prepared as to be readily absorbed and aid almost immediately in the process of reconstruction. It furnishes the sick with the largest possible supply of nourishment and with the minimum tax on the digestive organs.

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by increasing the number of Leucocytes, destroys toxic germs, increases the inherent resistance to disease, quickens glandular activity, arouses the nutritive forces, gives tone to the system, and stimulates cell-life throughout the organism.

Peptenzyme

is the only perfect digestive. It digests every variety of food. In physiological activity it presents the active and mother ferments of the entire group of digestive organs. It aids digestion by furnishing an additional supply of protoplasmic material out of which active ferments are elaborated, and perfects the process by increasing cellular activity.

Samples and literature on request.

Reed & Carnrick, - - New York.

THE CATARRHAL DIATHESIS.—In catarrhal affections of the various mucous membranes, particularly of the respiratory tract, there exists, not only a relaxed atonic condition of these structures, but an underlying constitutional state of malnutrition. All authorities agree that in order to eradicate the local pathologic conditions, treatment by appropriate systemic remedies is indispensable; the patient's nutrition must be fostered and restored so that a degree of constitutional vigor is attained which antagonizes the catarrhal processes. Gray's Glycerine Tonic Comp. is the remedy par excellence in these cases, because it has a two-fold action. Primarily and chiefly it overcomes malnutrition; it re-establishes normal nutrition by eradicating the ever-present atonic condition of the digestive organs, thus assuring the maintenance of normal digestion and assimilation of food; restoration of tone and nervous force to the entire system, and incidentally to the mucous membrane, is a natural sequence. Gray's Glycerine Tonic Comp. has, moreover, a direct local antiphlogistic and tonic influence upon the disordered circulation of the mucous membrane; it relieves engorgement and restores tone to the relaxed atonic blood vessels. This remedy will prove effective in obstinate and recurrent catarrhal affections of the respiratory and gastro-intestinal tracts which have resisted all other treatment. The Purdue Frederick Co., Sole Proprietors, 15 Murray St., New York.

Anemia Pseudoleukemica.—Under the name of anemia infantum pseudoleukemica, Dr. S. Klein describes a severe form of anemia peculiar to children. This condition was first mentioned by von Jacksch, and is characterized by the presence of more or less intense anemia, by a marked enlargement of the spleen, by an increase in the size of the liver, and by considerable emaciation. In these cases the blood is found to contain a large number of nucleated corpuscles, both normoblasts as well as megaloblasts, and an excess of leukocytes. The number of neutrophiles and multinucleated leukocytes being thereby considerably diminished. These cases closely resemble ordinary leukemia, but differ from it in the absence of extreme leucocytosis, while the prognosis is also more favorable. The disease usually occurs during the first year of life, and is especially frequent in children of the poorer class of people, owing to an insufficiency of nourishing food. The treatment consists in careful hygiene, in the administration of some ferruginous preparation, and in proper nutrition. Among the chalybeate remedies the author found Ferro-somatose of especial service, giving it in doses of 20 grains three or four times daily. In the eight cases which are reported in detail, the percentage of hemoglobin as well as the number of red blood corpuscles rapidly increased under the administration of Ferro-somatose, which is attributable, both to the nutritive action of somatose and to the prompt assimilation of this organic iron preparation into hemoglobin. In milder cases complete recovery resulted in one month, while in the more severe it was prolonged over two months in only one instance.

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Septicemia Post-Abortion.—Dr. Robert H. Lawrence, Chicago (*Amer. Gynec. & Surg. Jour.*), reports a case as follows: Mrs. D. A., aged 23, married five months; aborted October 1; saw her on October 5; she was septic, temperature 103°, pulse 122; curetted and gave carbolized douche. In the evening temperature went to 104°, pulse 150. Gave stimulants and intra-uterine douche, Borolyptol ℥ii, and vaginal douche, carbolized water. October 6, 2:30 P. M., temperature 104°. Consultation with Dr. A. McDiarmid; curetted again and used 1-3000 bi-chloride intra-uterine douche, which was followed by chill, abdominal tenderness, and temperature rose to 105.5°, pulse 140. October 7, temperature rose again; gave another bi-chloride douche, followed by chill, etc. Then discontinued bi-chloride and used Borolyptol intra-uterine douche twice a day, with the result that on Oct. 21 patient was discharged cured. Is much pleased with the action of Borolyptol in this case as compared with bichloride. No pains, chills or rise of temperature followed its use. Considers Borolyptol superior to sublimate for these cases.

We call the attention of our readers to the advertisement of the Robinson-Pettet Co., Louisville, Ky., which will be found on another page of this issue. This house was established fifty years ago, and enjoys a widespread reputation as manufacturers of high character. We do not hesitate to endorse their preparations as being all they claim for them.

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FELIX PAQUIN, Ph. B.,

Chemist and Bacteriologist of the Board of Health.
Member of the Association of Official Agricultural Chemists.

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ORIGINAL ARTICLES.

TYPHOID FEVER,
WITH SOME OF ITS COMPLICATIONS AND SEQUELÆ*

BY A. E. COX, M.D.
MILAN, TENN.

Prior to the nineteenth century, typhoid fever was practically unknown. In the early part of the nineteenth century observers and clinicians began to notice a difference in the types of continued fevers. Huxham in particular, and Brettonnau in 1813 distinguished it to be a separate disease. In 1829 Louis' Practice appeared, in which typhoid fever was probably first described and named. Gerhard, of Philadelphia, who had been a student of Louis', was the first to clearly lay down the difference between the two diseases. This was in 1837. Typhoid fever is described as an infectious, specific, febrile disorder, characterized by hyperplasia and ulceration of the lymph glands of the intestines, with the constant presence in them of the bacillus of Eberth, and enlargement of the spleen. The disease is marked clinically by fever, diarrhea, abdominal tenderness, tympanites, and a rose-colored eruption situated on the abdomen and chest.

Typhoid fever is practically a disease of the temperate climates, though it prevails to a greater or less extent in the tropics, and is

* Read before Tri-State Medical Association, Memphis, November, 1899.

not unknown by any means in the colder countries. It prevails extensively and sometimes epidemically throughout all portions of the United States and Canada; in more recent years, since its etiology has been better understood, epidemics are becoming more rare, probably because of better sanitary conditions. Season exerts a great influence upon the prevalence of the disease, more than half of all cases occurring during the months of August, September and October, and by some authorities it has been designated "autumnal fever." It has been observed that typhoid fever prevails more extensively after long, hot and dry summers, and different theories have been advanced in explanation of this. Buchanan holds that the lower the water is, the greater the amount of solid matter that must be suspended in it. Should there then be germs in the soil, the water will contain them in larger proportion and be to that degree more poisonous. Dust is thought to be a medium through which the germs are often transmitted, and in support of this theory the following may be offered: The spread of typhoid fever at our various military camps during our recent war, was all out of proportion to a spread which might have resulted from contamination of drinking water, which is admitted to be the usual manner or medium through which it is transmitted; as in camps which used artesian water the disease prevailed the same as in camps where the artesian water was not used.

In a paper read before the British Medical Association, Dr. Jno. Robertson, Medical Officer of Sheffield, on "Soil as a Factor in the Spread of Certain Diseases," maintains that while the water carriage of typhoid infection is important, the attention given to it has obscured the relatively still more important subject of dust or filth-borne typhoid. He has studied the subject carefully, and finds that in over 80 per cent. of the earlier cases the theory of water or milk infection will not suffice to account for the occurrence of the disease. He finds also that the typhoid fever dies out quickly in grass-covered areas, that when planted beneath the surface it has a tendency to extend upward rather than downward, and that it is capable of living and multiplying in the ordinary surface soil. The transference of the germs from the soil to man is made, he feels assured, under certain conditions, chiefly through the medium of aerially-carried dust. Of course it must be borne in mind that the disease is not always transmitted through the medium of drink-

ing water, milk or dust, but sporadic cases occur where there is no trace of infection through these sources, and some other explanation must be offered.

Males and females are about equally liable to the disease, though males are more often admitted into the hospitals than females, because they congregate in cities where the infection of typhoid is more rife.

Typhoid fever is essentially a disease of young adult life, though it may occur in childhood or in old age. There is a marked susceptibility to the disease on the part of some families, and there is a difference in the susceptibility of different individuals in the same family. A change of residence, habits and modes of life seems to predispose to the disease; in fact, anything which causes a catarrhal state of the intestinal mucous membrane will determine somewhat the occurrence or non-occurrence of the disease. The state of any one's health outside of the intestinal catarrh has little or nothing to do with the development of typhoid fever. Influences which depress, such as overwork, anxiety, nostalgia, etc., may reduce the tone and resisting power of the system to such an extent as to render it susceptible. The specific germ, as described by Eberth, is a short, thick bacillus, motile, and with rounded ends, on one of which there can usually be seen a round, glistening body, believed by some to be a spore. It grows on various nutritive media, such as potato, gelatin, agar, blood serum and bouillon, and also in milk, and in the latter they become very large. These bacilli produce various poisons called ptomaines, typhotoxins, toxalbumins, etc., and it is the absorption of these poisons which produces the characteristic febrile reaction which in due course of time, provided the febrile stage lasts long enough, produces the typhoid state.

In the vast majority of cases the bacilli find their way into the organism through the intestinal mucous membrane, having been imbibed in drinking water or milk, or as already set forth in this paper, by inhalation of dust containing them, and finding lodgment in the mucous membrane of the lungs. As to what takes place after the bacilli gain entrance into the organism is as yet not definitely known. They may multiply in the alimentary tract, but it is very probable that they immediately penetrate the intestinal mucous membrane and lodge in the lymphatic tissue of the bowel, the mesenteric and lymphatic glands, and in the spleen and liver.

Typhoid fever is not a very contagious disease. Only those who come in close contact with it by handling the bedpan, linen, etc., are exposed, the exhalations from the lungs and skin being practically harmless. After the germs gain a foothold, we know quite well the results. Hyperplasia of the lymphatic follicles of the lower portion of the ileum and cecum always occurs, and the jejunum and colon may likewise be involved, and in rare instances even the duodenum, stomach and rectum.

Peyer's patches usually receive the brunt of the infection, becoming swollen, enlarged and prominent. The infiltration may extend beyond these glands into the muscular, and in rare instances into the serous coat. Following this hyperplasia we have necrosis of the tissues and sloughing, which gradually spreads from the edges inward, leaving a raw surface, an ulcer, which must heal by granulation. If the necrosis of the tissues extends far enough, we have perforation of the bowels, and we may have, and usually do have, hemorrhage when the necrosis is marked in either the inner or middle coats of the bowel. The spleen, liver and kidneys are more or less involved, each organ being enlarged, and in the case of the spleen it sometimes becomes excessively large, even to the point of rupture.

Apropos of some of the changes above referred to, I want to report a few cases which have come under my observation.

Case I. A. E. C., the writer, at 21 years, was confined to bed first, October 8, 1893. For a week previous to this I lay around, feeling not well, but up most of the time; had headache and backache, with a marked pain in the back of the head and neck; acute coryza, indigestion, constipation, and a general feeling of malaise, and tongue coated white. Temperature, October 9th at 10 A.M., was 103°, pulse 100; at 2 P.M. temperature was 105°, pulse 100; at 6 P.M. temperature was 104°, pulse 100; at 12, midnight, temperature was 102½°, pulse 100; October 10th, 6 A.M., temperature was 102°, pulse 96; at 10 A.M. temperature 103°, pulse 100; at 2 P.M. temperature 105°, pulse 100; 6 P.M. temperature 104°, pulse 100; 12, midnight, temperature 102½°, pulse 102; October 11th, 6 A.M., temperature 102°, pulse 102; 10 A.M. temperature 103½°, pulse 104; 2 P.M. temperature 104½°, pulse 104; 6 P.M. temperature 105°, pulse 104; midnight temperature 103°, pulse 104. The temperature and pulse curve seemed to remain for the next few days as stated above until October 15th, when there was a sudden drop in temperature to 97°, but pulse rose to 130 per minute, weak and compressible; pupils became dilated, skin moist, cold and clammy. Of course the trouble was very apparent. Within a short while I had several large and bloody stools; my condition grew worse steadily, and it seemed that the end was near at hand; pulse was hardly perceptible, temperature remained sub-normal; pupils widely dilated, respiration shallow and irregular, extremities cold, and there was no improvement for thirty-six

hours; but at the end of this time my condition began to improve, pulse became a little stronger and not quite so fast; temperature gradually rose to 103°. For the next week my condition was extremely grave; there was coma vigil, subsultus tendinum, delirium of a low muttering character, sordes on teeth; temperature ran high, from 103° to 104°, pulse from 120 to 130 per minute; meteorism was marked. I was so weak that I could not raise my head off the pillow. Treatment was, for fever, cold water in line of a sponge bath; for hemorrhage, acetate of lead and opium; pabulum, milk, chicken broth and beef tea, and plenty of water to drink. I am indebted to my preceptor, Dr. T. E. Stokes, for the report of this case.

Case II. J. H., æt. 28. I saw him first September 19, 1895. He gave the following history: About the middle of August he was taken down with some kind of fever which lasted about a month. Immediately after his fever subsided he came from Alabama to Humboldt, Tenn., and while on the trip he became delirious with a recurrence of the fever. When I saw him he was very much emaciated, fever 103°, pulse 120 per minute, tongue was clean, bowels began running off and never checked, meteorism became very excessive, singultus developing on the twelfth day, and my patient died two days later from exhaustion. This case is reported only in part, as I have lost some of my notes and cannot recall all the facts in the case.

Case III. Minnie R., æt. 18. I saw this case in consultation with Dr. H., August 6, 1896, at 9 A.M. The patient had then been sick eight days. Her symptoms were as follows: Tongue coated with a brown coat, edges and tip clean, with the latter somewhat red and furry; abdomen tender in right iliac fossa, spleen enlarged, temperature 104½°, pulse 120 per minute; diagnosis, typhoid fever. Treatment recommended was sponging for fever, strychnia to support the heart, sulpho-carbolate of zinc as an intestinal antiseptic; milk and the animal broths was the diet. This patient progressed nicely, and by the end of the third week was convalescent. Her mother gave her an apple on the third day after the fever had reached normal, and the patient died twenty-four hours later of perforation of the bowel.

Case IV. C. H., æt. 38; October 15, 1896, first saw patient. Temperature was 102°, pulse 90, tongue furred, emesis marked, bowels constipated, headache, backache; diagnosis, remittent malarial fever; treatment, quinin as an antiperiodic, calomel as a purgative, and other symptoms met as they arose. After noting that treatment did not better my patient's condition I examined very closely for typhoid fever, and found the clinical symptoms present and the treatment was changed. This patient had a typical attack of typhoid fever, which ran the usual course during first attack. He suffered a relapse which ran a three-weeks course, and during second and third weeks of this relapse he became unable to void his urine, and his bowels were so constipated that it was difficult for him to have an action under any circumstances. He seemed to have lost control of the expulsive power of both bowels and bladder. He also suffered with violent attacks of enteralgia, which were usually allayed by turpentine stupes and heat locally applied. For some days after subsidence of fever this inability to void urine and feces persisted, but it gradually passed off as convalescence was established.

Case V. Lucile B., æt. 8. She was seen first September 1, 1897. She presented an atypical clinical picture of typhoid fever, which ran rather an irregular course, in fact I would at times doubt if I had a case of typhoid fever, and would allow a somewhat liberal diet, when the symptoms would become aggravated, and on the fifteenth day she had two decided hemorrhages from the bowels, which were promptly

controlled with morphin hypodermically. She improved every day after having the hemorrhages, and by the twentieth day was free of fever.

Case VI. Jennie K., æt. 25. She was seen first September 4, 1897. Temperature 102°, pulse 106 per minute, headache, backache, tongue heavily coated, bowels running off, abdomen tender, especially so in right iliac fossa, rose-colored macular eruption over chest and upper portion of abdomen. Bronchitis was marked throughout the attack, which lasted some twenty days. So marked was the bronchitis that it completely masked the true condition if one was not careful to note the chief symptoms of typhoid fever. Recovery complete.

Case VII. J. H. I first saw him July 19, 1898. He had clear symptoms of typhoid fever, and the disease ran rather a protracted course, but on thirty-second day he was free of fever and in fair condition. Two days later his bowels began to run off, probably from the effects of overfeeding, and nothing I did had any effect in checking them. My patient died three days later from sheer exhaustion.

Case VIII. Elsa B. I saw her in consultation with Dr. C., February 2, 1899. Her history was somewhat as follows: During the latter part of the summer of 1898 she had an attack of typhoid. She recovered sufficiently to be up and around after having the fever, but could never say that she felt well. When I saw her she had a cough without expectoration, dyspnea on the least exertion, chills with rise of fever twice daily, sweats profuse, pulse 120, dullness on percussion over entire left lung; aspiration in sixth intercostal space revealed the presence of pus. An operation of resection of the ribs for the relief of the empyema was advised, but it was promptly and persistently refused by patient. She was told the inevitable result if she did not submit to the operation, but she answered by saying, "let me die," which she did a few weeks later.

Case IX. Jim. E., æt. 25; family history good. This case I saw in consultation with Dr. R., August 29, 1899. His physician informed me that during the first week he was not able to make a differential diagnosis between malarial remittent fever and typhoid; but at the time I saw him, beginning of the second week, symptoms pointed to typhoid fever. This patient's stomach was so irritable that it would not retain any thing. Strychnin was administered hypodermically, and rectal alimentation resorted to. I saw the patient again two days later, and succeeded in allaying emesis with cocain; rectal alimentation continued, strychnin continued. Again on September 9th, ten days later, I saw the patient and found him suffering from hemorrhage of the bowels, and as he was already weak I felt that it would take but little to carry him off. His physician had already given him morphin hypodermically. I simply advised the drug continued *pro re nata*, and suggested protonuclein in ten gr. doses, to be given every four hours, which was consented to. It was given in powdered form, dry, dropped on tongue and swallowed with little water. This was the first medicine given by the mouth and retained for ten days. Rectal alimentation was discontinued, owing to increased peristalsis and hemorrhage. Patient promptly stopped bleeding, and retained his strength for some days on nothing but protonuclein. Strychnin was continued hypodermically; his stomach began to tolerate small quantities of milk, which was increased until he took two pints per day. He made an uneventful recovery.

Case X. Geo. S., æt. 23, married; family history good. September 9th at 10 P.M. I first saw him. His symptoms were: Fever 103°, pulse 106, headache, backache, epis-

taxis, abdominal tenderness, diarrhea with brown coat on tongue, spleen could be palpated below margin of ribs, liver enlarged and tender to pressure. A physician had seen him every day for a week, and had made a diagnosis of malarial fever; had dosed him with quinin in large doses. Three days later I saw him again, and found all of the above symptoms intensified, with very marked tenderness over both kidneys, a rose-colored eruption over chest, and to make a diagnosis now was a very easy matter. The case progressed in the usual way for a case of typhoid fever to progress until the beginning of the fourth week, when I noticed that the urine was too red, and by the end of twenty-four hours the hematuria became well marked, and a slight hemorrhage from the bowels developed; purpura was noticed first on chest, but later became marked on other parts of the body. These hemorrhages increased steadily until my patient succumbed four days after their first appearance.

Case XI. Odell C., æt. 20, single; family history good. On September 3, 1899, I first saw him. His symptoms were very misleading during the first ten days of his sickness, as they were very much like those of malarial remittent fever, and I treated him accordingly until I observed that quinin had not the effect characteristic of it in malarial fever. Up until this time there had been no symptoms which characterize typhoid fever, save that the fever remitted. At this stage there developed a diarrhea, with slight tenderness in right iliac fossa. For the next eight days I treated this case as typhoid. During the latter part of the first week of convalescence a venous thrombosis developed in left femoral vein, which caused edema and tenderness of the left limb, especially along the femoral vein, which could be felt to be swollen and hard. The calf of the leg became rather markedly swollen, and was more elastic; nor would it pit, as is the case in ordinary swelling. The limb was powerless, and there was a slight fever which accompanied the swelling, tenderness and increased weight of limb. Convalescence was somewhat more tedious in this case than is ordinarily so, but recovery was complete.

The typical symptoms of typhoid fever should be and are recognized by most clinicians, and unless one is very cursory in examination there need be no trouble in making a correct diagnosis; but there are cases, and especially in the earlier stages of the disease, when one cannot say whether there is typhoid, malarial remittent, or some other fever present. To illustrate the difficulty of making a differential diagnosis in some cases at all stages, I cite some passages from Osler's Practice of Medicine. On page 33 he says:

"The early and intense localization of symptoms in certain organs is a frequent source of error in diagnosis. The following are the most frequent deviations from the normal course: *a*, onset with pronounced nervous symptoms; *b*, with pronounced pulmonary symptoms: *c*, with intense gastro-intestinal symptoms; *d*, with symptoms of acute nephritis. Cases coming on with severe headache, photophobia, delirium, twitching of the muscles and retraction of the head, are almost invariably regarded as cerebro-spinal

meningitis. I have thrice performed autopsies on cases of this kind in which no suspicion of typhoid fever had been present, the intense cerebro-spinal manifestations having dominated the scene. Fully one-half of the cases of so-called brain fever belong to this category. Misleading pulmonary symptoms occasionally develop at the very outset of the disease. The bronchitis rarely causes error, though it may be intense and attract the chief attention. More difficult are the cases setting in with a chill and followed rapidly by pneumonia. I have brought such a case before my class one week as typical pneumonia, and a fortnight later shown the same case as undoubtedly one of typhoid fever. In another case in which the onset was with definite pneumonia, no spots developed; and though there were diarrhea, meteorism and the most pronounced nervous symptoms, the doubt still remained whether it was a case of typhoid fever or one of pneumonia in which severe secondary symptoms developed. There is less danger of mistaking the pneumonia which develops at the height of the disease, and yet this is possible, as in a case admitted a few years ago to my wards—a man aged 70, insensible, with a dry tongue, tremor, ecchymosis upon the wrists and ankles, no rose spots, enlargement of the spleen, and consolidation of his right lower lobe. It was very natural, particularly since there was no history, to regard such a case as senile pneumonia with profound constitutional disturbances; but the autopsy showed the characteristic lesions of typhoid fever."

"The differential diagnosis between general miliary tuberculosis without local manifestations and typhoid fever is extremely difficult. The cough may be slight or absent. Diarrhea is rare in tuberculosis; the bowels are usually constipated, but diarrhea may occur and persist for days. In certain cases the diagnosis has been complicated still further by the occurrence of blood in the stools. Enlargement of the spleen occurs in tuberculosis, but it is neither so early nor so marked as in typhoid fever. In children, however, the enlargement may be considerable. The urine may show traces of albumin, and unfortunately the diazo-reaction which is so constant in typhoid fever, is also met with in general tuberculosis."

Typhoid fever has been mistaken for appendicitis. I was told of a case in one of the large hospitals of this country, in which the fever and the presence of a tender induration in the right iliac fossa seemed to indicate appendicial disease so clearly that an operation

was performed, but the induration was found to be the swollen ileum and adjacent glands. In a person who has had a previous appendicitis the diagnosis might be extremely difficult, as in a case mentioned by Da Costa.

Late in the convalescence of typhoid fever the symptoms of appendicitis may develop, due to the perforation of an unhealed ulcer. In the Widal test we have almost a positive sign of typhoid fever. The committee of the Section on Medicine of the American Medical Association says, "It must certainly be regarded as the most constant and reliable sign of typhoid fever, if not an absolute test." Cabot, in his recent work on "Serum Diagnosis of Disease," has compiled some 5978 cases of typhoid fever of which there were 97.2 per cent. which gave a positive reaction. This statement unquestionably speaks for itself, and in a most flattering manner. Some of these cases diagnosed clinically as typhoid fever and which did not give the positive reaction, might have been cases of mistaken diagnosis. Johnson, of Montreal, has demonstrated that the Widal test may be made with blood after it had dried, which adds materially to the value of the test, as a drop of blood may be placed on paper, allowed to dry and sent some distance before the test is made. According to the same authority, "All that is necessary in making the test is to have a good microscope with one-fifth to one-eighth inch objectives, a pure bouillon or agar culture of the typhoid bacillus, some cover glasses and slips, a platinum wire loop and a drop of dried blood from the case to be examined. With this simple outfit, combined with the necessary knowledge of bacteriologic technics, it is safe to say that in a vast majority of cases typhoid fever may be accurately diagnosticated as early as the end of the first week. After a diagnosis is made, then comes the complex question of treatment, every man having some treatment or other which he believes to be superior to that of some other, and from the fact that we have so many modes of treatment, they serve only to lead one to believe that none are very satisfactory.

Referring again to that high authority, Prof. Osler, he states that "the profession was long in learning that typhoid fever is not a disease to be treated by medicines. Careful nursing and regulated diet are the essentials in a majority of cases." The plan hit upon by myself in my early experiences was that advocated by I. Burney Yeo, of London, which consisted in thirty grains of

powdered potassic chlorate placed in a twelve ounce bottle and sixty minims of strong hydrochloric acid poured on it and water added after the chlorine gas had been generated. Of this solution, one ounce in water was given every two, three or four hours, according to the severity of the case. Quinin in three doses of four grains each was given during the twenty-four hours, and other symptoms were met with an appropriate remedy as they arose. Of course the general management of any patient is that which is ordinarily adopted in any case of acute disease. Plenty of fresh air in the room, an abundance of good, pure water, perfect rest in bed from the outset, frequent cleansing of linen and bed-clothing and absolutely fluid diet, milk being preferred. My treatment at present is a modification somewhat of the above; the intestinal antiseptic (if there is one) is the liquid guaiacol.

I have never noticed any antipyretic effect from guaiacol when the medicine was administered internally. It is given for its antiseptic properties, and after giving it for some little time, the stools become redolent with the characteristic odor, showing that the medicine must have passed over the diseased surfaces as guaiacol and rendered these parts antiseptic. When the liquid guaiacol is not well tolerated by the stomach, I use guaiacol carbonate. I use calomel with soda at first every two hours to procure a thorough evacuation of the bowels and get a full flow of bile, which latter is nature's antiseptic. Salines increase the effect of these drugs and the effect of the guaiacol is augmented.

The impression is common that the administration of cathartics in typhoid fever is dangerous. This error is founded upon the fact that diarrhea is present usually, and the fear that the cathartics will debilitate the patient by increasing the flux, and upon the fear of precipitating an intestinal hemorrhage by stimulating peristalsis. When we remember that the diarrhea is almost entirely symptomatic, caused by the irritating presence of micro-organisms and their accompaniments in the intestines or excessive or undigested food, and will subside in proportion as we are able to remove the cause, if our method of removal does not of itself produce deep-seated irritation, the danger of tearing open an artery through an intestinal ulcer is practically nil, when the stimulation of intestinal movements is as gentle as it is when such agents as the salines are used. As a matter of fact you are doing a vast deal toward arresting the fur-

ther progress of an ulcer that might later cause a perforation, by removing, more or less thoroughly, the primary cause of tissue destruction, infectious bowel contents, etc.

Strychnin is administered from the outset in 1-40 grain dose every six hours, and when there is a tendency to gradual failure of the heart, it is given more frequently. You have doubtless noticed that in some of the cases reported in this paper, I gave treatment, while in others I did not. In those cases in which I did not report treatment, the ordinary treatment which has already been outlined was given.

In conclusion, I want to say that this subject has not been thoroughly covered, nor did I intend to do so, but desired to give my experience with some cases of typhoid fever which have been of unusual interest to myself, hoping that my paper might elicit a discussion that would be beneficial to all.

MANAGEMENT OF THE INSANE.*

BY N. F. RAINES, M.D.
MEMPHIS.
Physician in Charge of the Shelby County Poor and Insane Asylu

In considering the Management of the Insane I shall confine myself to my experience in caring for the insane in the Shelby County Insane Asylum. As we now have a hundred and twenty inmates, who present nearly all the types treated in more pretentious hospitals, I have thought it would be interesting to know with what success our labors are rewarded.

The theory upon which I proceed, in the treatment of the insane, is that the patient should be prevented as far as possible from brooding upon his condition. His disease is aggravated by thinking about it, and I try to place him in an environment where pleasing diversions always occupy his mind, and there is nothing to remind him of his misfortune. For this reason I protest against the name "Insane Asylum." The word asylum carries with it the hopelessness of a living graveyard, and is beyond doubt a cause which keeps incipient cases of mental aberration outside its walls when treatment would promise the very best results. Perchance "a rose

* Read before the Tri-State Medical Association, November, 1899.

by any other name would smell as sweet," but in this case I firmly believe infinitely better results could be obtained if the name of the "Shelby County Insane Asylum" were changed to the "Shelby County Hospital for the Insane."

It has been my ambition to make this place one of active treatment and not one of simple safe-keeping—a hospital in fact. When I say treatment I do not mean medication alone, but whatever means will restore to the normal the dethroned reason.

Mental deviations from the physiologic form must be met with measures of a psychic nature. To do this with the assurance of success we must enter the life of each and every patient. The subtle influence of a sympathetic, now cheerful, now more serious personality, on a great majority of the insane, cannot be overestimated. In spending our days among them we must be like the very sunshine to them, cheering and inspiring them with that essential element of human happiness, hope.

Patients are fully aware that the superintendent holds the key that intervenes between them and liberty, hence it is not an easy matter to insinuate himself into their friendship. The prison-keeper should be merged in the friend, willing at all times to hear the appeals of the poor sufferer.

Attendants. Much depends upon a judicious selection of attendants. Cleanliness, light, air, exercise, patience, kindness and liberty are the watchwords of treatment impressed on my subordinates at my monthly "cabinet meeting." The attendants are constantly with patients, the physician as often as may be. Patients seem to lose all idea of veracity, hence their statements must be taken *cum grano salis.* For instance, he tells you he has not tasted food all day, when he enjoyed a hearty dinner; his bowels may have been moved that morning, and yet he tells you he has not had a movement for a week. This is always the case with the masturbator, whose nocturnal revelries must be detected and reported by the attendant.

Exercise. Prolonged mental enfeeblement is usually accompanied by brain atrophy, and prolonged mental disturbance by structural brain changes. We constantly put into active exercise certain healthy forms of energy in order to diminish other morbid forms. We try to ascertain their various temperaments, and encourage whatever form of diversion or occupation is permissible. Most of the work is done by the inmates. Those who are unable to

perform manual labor are required to take daily walks beyond the boundaries of the campus, when the state of the weather will permit. This not only gives an opportunity for thorough ventilation of their apartments, and enables the patients to inhale the pure oxygen; but they become so tired they are perfectly willing to sleep in peace. They do not make night hideous with piercing screams nor require a sleeping potion to woo the drowsy god.

Pleasures of patients. The fly on the dome of St. Peter's can see but eight feet, yet it is all the world to him. Even so the grounds of the Asylum limit the horizon of the lunatic's world. It behooves us then to beautify and adorn this world with all the allurements of art and all the embellishments of fancy.

The question of entertainment is important, for amusement means a great deal more for the insane than for the sane, to whom applies the old saying, "All work and no play makes Jack a dull boy." It is not only intended to amuse, to break the humdrum of the daily life, but it is planned with the intention of diverting the patients from themselves, of making them forget their woes and troubles—products of the imagination of a diseased brain, but as real, as true to them, as the heat-giving powers of the sun are to us.

We have weekly parties where some dance and others engage in social conversation. Card playing is allowed. Congregational singing is encouraged in the weekly services conducted by the Pastors' Association of Memphis. Music is given the high place it deserves. If music hath charms to soothe the savage breast, much more does its soothing power influence the disordered brain.

We encourage out-door games. We have croquet grounds, and a tennis court. We have hammocks and swings scattered over the grounds, and inviting benches adorn our lawns. Reading matter is distributed whenever donated.

Cultivating self-respect. I do this by treating all of them with due consideration, and making it a part of their discipline that they are to treat each other with proper respect. This convinces them that they are men and women and not social outcasts, and they will, in many instances, repay in good behavior the trouble taken. The wards and hallways are kept as attractive as possible. Visitors notice this, and immediately determine that the patients are satisfied with their lot. They forget that bare walls, be they ever so clean, do not inspire with a feeling of comfort those sur-

rounded by them. A clean prison is better than a dirty one, but still it is a prison. If I could, I would have a piano or music box in every ward. As it is, I have as many pictures and potted plants as are obtainable.

Food. The animal and organic functions are so interwoven with the purely mental functions, that we must look on the whole man, body and mind, from the point of view of an organism whose whole needs and capacities exhibit unity and solidity throughout. When we remember that different kinds of food affect the mental development of whole races of men, it is not surprising that we look to the food supply largely to preserve this equilibrium between mind and body. Hence we carefully regulate not only the kind of food furnished, but its preparation. We especially guard against overfeeding, as patients will gorge themselves like pigs, but unlike pigs, they suffer the consequences. This dependence of the appetite for food on a sound working brain is more clearly shown in those cases that refuse all food and must be fed by force.

Dining rooms. Each of our six wards has a separate dining service. I cannot too strongly condemn the congregate table. The conduct of some persons at a congregate table is so unpleasant that others cannot eat while looking at it. We give the patients knives, forks, plates and soup bowls, cups and saucers. In the violent wards the tin utensils are used because the patients will hurl them about the table.

Individual baths. Every patient is required to take a warm bath in a separate bathtub once a week, some daily. All the writing material they ask for is furnished, but their mail is under my surveillance. The paranoiac is never stinted in paper, ink or pencil. For him letter writing is as essential as daily bread. His correspondence, of course, goes to the waste basket. The paronoiac derives much greater pleasure in writing his communications than in receiving replies to them.

Mechanical restraint. The total abolition of mechanical restraint in an insane hospital is an absolute impossibility. It must be used in some cases. A maniac who nightly destroys his mattress, bedding and clothes, all made of duck; a melancholiac with tendencies to aggravated self-flagellation; a patient afflicted with traumatic insanity, whose frenzy at times equals that of the epileptic maniac; a paralytic dement in his unbridled abuse toward his fellow suf-

ferers; a patient afflicted with a surgical injury and an uncontrollable desire to rid himself of the surgical dressing—without mechanical restraint there is but one way of managing these cases, and that is by an unmerciful system of drugging.

The problem simply resolves itself into a question of chemical against mechanical restraint, and I give the latter the palm of superiority without a moment's hesitation. Mechanical restraint employed by means of padded or pliable appliances is to be looked upon as a blessing in disguise in treating some cases of mental aberration. We must preserve their vital energy—mechanically if we can, chemically if we must.

Visiting patients. As long as a patient is confided to my care, I deem it my duty to defend him against any injurious influences, and such influences may emanate from the nearest and dearest of kin. Curiosity seekers are rigidly excluded from the violent wards. Many people are still possessed of the superstitious belief that their insane brethren are all but devoid of human semblance, terrible but terrifying freaks of cruel nature. I have repeatedly had delicate young girls to ask me, after being shown through the mild wards, "Where are those who rave?" I have flatly refused to admit some visitors who mistake our institution for a free-for-all dime museum, filled with freaks and monstrosities, open at all hours for the gratification of their morbid curiosity. Sympathy is what the poor unfortunate needs, and sympathy should be the motive leading to such visits, or, if curiosity, it should be exhibited on the way home, and not before the patients.

Each case separate. Individualization is the *sine qua non* in the achievement of any satisfactory results. In no department of medicine is Crockett's saw more applicable—"Be sure you are right, then go ahead." We must take time to ascertain the normal workings of the patient's brain—his heredity, temperament and habits—in order to understand its abnormalities. It is of the first importance to accurately diagnose each case. This requires a great deal of time, but no work of the superintendent could be more important. What to him would be the mere whistling of the wind, would to the patient be the whispers of a guardian angel guiding his frail bark into a haven of rest. The court has wisely built a beautiful cottage on the asylum grounds for the superintendent, thus enabling him to see more of his patients. To encourage a more intimate

relationship with my patients, I have removed from my office the chilling halo of a sanctum sanctorum. I often invite patients to a *tête á tête* in my office, where they pour out their souls to me, from which I frequently get points valuable to treatment.

Home treatment. As to home or asylum, I do not hesitate to decide in favor of the latter. The exceptions seem to be in the case of the wealthy who have every advantage—of trained attendants, travel and environment. It is not unusual to receive a patient described as "a holy terror" at home, and soon have him docile and obedient. He soon finds out it is useless to resist, and yields gracefully. The indulgence born of love on the part of parents and guardians is responsible for his intractability.

Medical staff. I have been very materially assisted in treating my patients by a medical and surgical staff of bright young physicians, surgeons and specialists of Memphis. We have several times removed the cause in ovarian and masturbational insanity, with entire relief.

Other hospitals. I have had much pleasure as well as profit in visiting the three hospitals in our State, the County Asylum of Davidson County, the Arkansas State Asylum, the Cook County Insane Asylum of Chicago, the Milwaukee Hospital for Insane, and the St. Louis Asylum for the Insane. I am indebted to Dr. Edward C. Runge, superintendent of the latter asylum, for many thoughts used in this paper.

To recapitulate. I would say we rely largely upon the environment which we establish to procure cures. Of course we resort frequently to medicine, but it varies in every case. Plenty of fresh air, good nourishing food, exercise in some cases, rest in others, fill the most important place among our curative agencies. We must love our work if we do it well, and it must not be the lukewarm love of the bread-winner, but the ardent love of the enthusiast. How can it be otherwise? Every day brings in its wake new pictures, unexpected turns, and richer for having lived the day, we pass into the next. As the child turns the kaleidoscope, bringing new pictures to his delighted vision, even so the physician in his daily rounds is delighted with the truly kaleidoscopic variety of human minds and human souls.

SOME
OBSCURE AND OBSTINATE CASES OF NEURALGIA.*

BY HENRY POSERT, M.D.
MEMPHIS.

It is my intention in this paper to mention only such neuralgias as are either obscure in origin, atypical in their course, or obstinate to treatment. I shall also suggest some measures which I have sometimes found to be beneficial. I shall therefore leave out the various well-known forms with which we are all well acquainted.

In order to give some form of arrangement it will probably be most convenient to start at the top and finish at the bottom—i. e., beginning with the neuralgias of the head and ending with those of the foot.

Among the former I find that supra-orbital neuralgia is one of the most formidable and obstinate forms. Its cause is difficult to find. Errors of refraction have no bearing upon it—first, because they are seldom present, and second, even if corrected it does not cure. I have frequently called in to my aid the eye specialist, but without benefit. I know that often a gouty or rheumatic diathesis or malarial intoxication is assigned as a cause. But hunt as you may for it, you will seldom detect it. Even where the attacks show a certain periodicity we must be careful not to pronounce it of malarial origin. Quinin or any other antiperiodic almost never relieves it.

If I should judge from personal experience, I would make a tentative suggestion that the seasons have something to do with it. I have seen more cases in the early summer than at any other time. These cases have this peculiarity about them, that the attack begins about 10 in the forenoon and the paroxysm reaches its height at noon, when it rapidly declines. The only remedies that I found of any use were cold locally, painting the parts with guaiacol, menthol, absolute alcohol and hyoscyamin, aconite, cannabis indica and caffein internally.

Cervico-occipital neuralgia is another of this class. It is either limited to the great occipital or it may involve the four upper cervi-

* Read before Tri-State Medical Association, Memphis, November, 1899.

cal nerves. The pain is often very intense and the various anti-rheumatic and anti-neuralgic remedies are absolutely powerless to give relief. The only drug that is occasionally of some value is antikamnia in large doses.

Brachial neuralgia is, as everybody knows, a formidable and obstinate disease in a great many patients. It is often of rheumatic origin, but one form which is almost exclusively confined to the circumflex is especially obdurate. You can sometimes go through the whole gamut of anti-neuralgics without any success unless you resort to morphin, or occasionally cocain.

I have seen a number of cases of neuralgia of the chest that almost simulate angina pectoris, but have none of its characteristics. While it infringes upon regions supplied by the phrenic, it never is typical enough to call it so. It is a severe pain on the left side of the chest, just below the second rib, shooting upward, as in phrenic neuralgia, to the neck and half way down the upper arm. We might call it topoalgia as Blocq suggests, for pains in regions that are not anatomically outlined. This form, though rather troublesome and of some duration, generally gets well.

Though most dorso-intercostal neuralgias are contracted from la grippe or malaria, we sometimes meet with a form that cannot be ascribed to any of the variously known dyscrasias and which therefore resist treatment for a long time. I have found, however, that galvanism, quinin, salicylate of soda combined with small doses of codein, will sooner or later effect a cure. But there is one form of neuralgia of the back that defies all treatment. It generally extends from the sixth dorsal spine to the last. It differs from hysterical spinal irritation, that it is not upon the spine and not sensitive to light touch, but it is on the side, almost exclusively confined to the erector spinæ muscles, and is deep-seated. It is so violent that the patient will lie awake at night in intense agony. I have seen it in persons without a single hysterical stigma, without any gastro-intestinal, renal, hepatic or uterine trouble. These cases are temporarily relieved by dry heat and some of the coaltar derivatives.

To this class of patients belong also those with backache that is not rheumatic. Faradism long continued will sometimes effect a cure.

Another form of neuralgia that I have seen especially frequent in the early fall, which makes me think that it may be due to cold,

is severe neuralgic and myalgic pain in the lower portion of the gluteal region and in the minor branches of the sciatic. It generally attacks the right side, and is often so severe that the patient is confined to bed for days and weeks. Salicylate of soda is of no avail, nor is quinin, but hot baths, phenacetin, and later faradism, overcome the trouble, though it takes sometimes weeks to do it.

Most of the visceral neuralgias, excluding of course the kind known as colic, and those that are symptoms of disease of the abdominal and female pelvic organs, are usually hysterical stigmata. Though very severe and intractable at times, they are not constant, and recur at wide intervals, in fact, all hysteric neuralgias present a remarkable obstinacy, and if not on our guard we are liable to assign to them a more serious cause.

In the lower extremities I shall only mention two of importance, one of which is now happily curable. I refer to metatarsalgia, an affection located at the fourth metatarso-phalangeal articulation. I have seen one case that was so severe that the patient consented and the doctor amputated two toes, but without any permanent relief. Fortunately these patients are cured now by a shoe suggested to Prof. Gibney by an orthopedic shoemaker, which raises the arch of the foot and relieves the bone pressure upon this branch of the plantar nerve.

The other and the last form of neuralgia that I shall mention is one that is located in the back of the foot and extends sometimes to the outer ankle. The paroxysms are very frequent and severe, and outside of rest and moist heat, there is very little to do. Occasionally a high rubber heel will end the trouble.

I repeat in conclusion that I have not mentioned those causes which we all know are found in the majority of neuralgias, such as heredity, gout, rheumatism, syphilis, diabetes, renal and gastric diseases, hysteria, etc. The treatment in such cases, where we are fortunate enough to find the disturbing element, will suggest itself. But it is no use to disguise the fact that we meet with a great many cases that elude all detection of cause. There is no doubt that it is there, but so far it has not been found, and the lightly tacking on a name to it, does not make it so. It is better to acknowledge our ignorance, so that an unbiased mind may be prepared some day to find the true cause, and let us hope, the true remedy.

Southern Express Building.

XANTHOMA DIABETICORUM—REPORT OF A CASE.

BY M. B. HERMAN, M.D.
MEMPHIS.
Visiting Surgeon to St. Joseph's Hospital, City Hospital,
and Leath Orphan Asylum.

Mrs. F. S., aged 42, corpulent Jewess, widow and mother of several children, consulted me on November 30 for a very obstinate eruption on the dorsum of her right hand and upper lip, of over two years standing. She stated that she had never had any illness, and that she feels perfectly well, except that she has to micturate a little too often, having to get up once or twice during the night. Her bowels are regular; no headache or nausea. She is very much annoyed by the almost constant pricking and itching sensation of the hand and lip.

In viewing the eruption at a distance, it suggests a group of small nodules with a sloughy plug in the center of each one. Upon closer examination I found a group of well-defined conical papules, from the size of a hemp seed to a small pea, some of the very larger ones having yellow centers, very firm, with dark red areolæ, and sharply bounded from the surrounding skin. On inspection no other similar lesions were discovered on any part of the body.

The eruption suddenly appeared two years ago, upon the palmar surface of both hands, and after spreading slowly gradually disappeared, and later reappeared upon the dorsal surface of the right hand and upon the upper lip, involving the mucous membrane. The lesions were exactly alike in both groups.

An examination of the urine revealed a specific gravity of 1036, with sugar, albumin, and hyaline and granular casts.

Xanthoma diabeticorum is an extremely rare disease, less than twenty cases have been recorded, and nearly all the cases which have been reported have been in men under fifty years of age.

Bowen,[1] in his article on "Xanthoma Diabeticorum," says the lesions are especially common on the extensor surfaces of the body; and the elbows, knees and buttocks are mentioned as favorite sites in most of the recorded cases. They have also been seen on the scalp and face, and on the mucous membrane of the mouth. Unlike the lesions of the ordinary form of xanthoma, they have never, with one exception, been found on the eyelids, nor in the flexures of joints. The eruption may appear with very numerous lesions, or with comparatively few, the latter being the more common condition.

The affection is characterized by a great rapidity of development, the lesions appearing suddenly on the extensor surfaces of the

1 Twentieth Century Practice.

arms and legs and extending gradually to other parts. Another feature is their involution. Unlike the ordinary forms of xanthoma, after remaining stationary for a period varying from months to years, they begin to disappear rather suddenly and leave no scar. Not infrequently, however, they reappear at some future time. Diabetes is found in almost all instances, but a few cases have been described by Hutchinson, Besnier and Vidal, where this complication was not a feature. As far as I have been able to ascertain from the literature at hand, the first cases were described by Addison and Gull in 1851, and since by Robinson, Fox, Hardaway, Crocker and others.

The prognosis is favorable, the lesions disappear usually in the course of a few months, or lapse of several years, but may again appear in the course of time.

The treatment in this case has been that of diabetes—regulation of diet, increasing doses of codein sulph. and ten grain doses of potassium iodide t.i.d. Locally, I prescribed an ointment of white precipitate, thirty grains to the ounce.

At this writing the eruption has almost disappeared, but albumin, casts and a trace of sugar are still present in the urine.

Masonic Temple.

Utility of the Blood Clot in the Treatment of Wounds.—R. C. McChord (vol. 28, no. 1, of the *American Practitioner and News*), writes of his results in applying the Schede principle of moist blood clot organization to lacerated wounds of the soft tissues. When the tip of a finger has been torn off, leaving not more than one quarter inch of bone exposed, he forms the oozing blood into a cap fitting over the end, aiding the formation of the clot by blowing in iodoform powder. In other parts of the body, where the soft tissues have been scooped out, the clot is molded up level with the skin, soft rubber tissue is placed over and just beyond its edge, and over this a plain gauze and cotton dressing. The effect desired by the entire dressing is to maintain a moist aseptic clot until organization shall have taken place.

THE

MEMPHIS LANCET.

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EDITORIALS.

A SET-BACK FOR OSTEOPATHY.

DECISION ON OSTEOPATHY.—Harry Nelson, Plaintiff, vs. State Board of Health, Defendant, in Jefferson Circuit Court, Law and Equity Division.

Opinion by Sterling B. Toney, Judge.

SYLLABUS ON POINTS DECIDED.

1. The statutes of Kentucky against empiricism are constitutional.

2. Whether a school of medicine from which a party holds a diploma is a reputable medical college, is a question alone and exclusively for the State Board of Health to decide.

3. Mandamus will not lie to compel the said Board to decide a particular way. Their act is quasi judicial and is not subject to mandamus.

4. On the merits held, that the American School of Osteopathy at Kirksville, Mo., from which the plaintiff holds a diploma, is not a reputable medical college: and that the State Board of Health is right in refusing to allow the plaintiff to practice osteopathy in this State, etc., etc.

This is a suit in equity by the plaintiff, Harry Nelson, against the State Board of Health of Kentucky, to enjoin it from instituting or causing to be instituted against him a criminal prosecution, for treating or attempting to treat in this State sick or afflicted persons by the system or method of healing known and called "Osteopathy," and for practicing or attempting to practice medicine or surgery in this State according to said system.

He further avers in his petition "that he is a graduate of, and holds a diploma from, the American School of Osteopathy at Kirksville, in the State of Missouri, at which said institution he graduated December 15, 1897," and he alleges "that the said American School of Osteopathy is a reputable and legally chartered medical college, with a large and learned body of professors, and a large patronage of pupils."

In the first paragraph the defendant traverses the material allegations of the petition, and denies that the American School of Osteopathy at Kirksville, Mo., is a reputable and legally chartered medical college; denies that it has a large and learned body of professors; denies that the pupils are instructed or taught in any branch or branches of learning and science proper and necessary for the education of physicians or surgeons, or proper or necessary for the training or preparation of students for the practice of medicine or surgery; denies that its professors, or any of them, are capable of teaching any branch of science, or the principles of any branch of science or learning proper and necessary to be taught to students studying medicine or surgery; denies that the said school is entitled to the indorsement or recognition of the said State Board of Health, defendant herein.

In the second paragraph of its answer, the defendant alleges that the plaintiff, Harry Nelson, has not the education nor training legally requisite in this State for the practice of medicine or surgery, or any healing art or system of healing known to the medical and scientific world.

The defendant further alleges that the said American School of Osteopathy at Kirksville, Mo., and the system or method of healing which it proposes or attempts to teach or does teach, is not scientific nor based on scientific principles of medicine or surgery, or any other plan or method of healing the sick, or those suffering from any of the ills that flesh is heir to; but that on the contrary, the said doctrines, methods and principles for treating sick and afflicted persons, inculcated, taught and practiced at the said "American School of Osteopathy," are a complete system of charlatanism, empiricism and quackery, calculated and designed to impose on the credulous, superstitious and ignorant, and fraught with danger to the health, limbs and lives of the citizens.

The proof clearly demonstrated that the defendant, the State Board of Health, fairly and fully investigated the American School of Osteopathy at Kirksville, Mo. It sent a committee of three reputable physicians in the State to that institution, Drs. J. M. Bovine, George W. Griffith and H. A. Cottrell, to examine into its equipment, apparatus and facilities for teaching, and to see the professors, and ascertain whether they were ignorant pretenders or self-conceited visionaries or competent educators.

Dr. McCormack, the Secretary of the Board, a physician and surgeon of high character and distinction in this State, also visited Kirksville, Mo., and examined the American School of Osteopathy, and his testimony is in the record.

The proof shows that the said investigation and examination by the said Board through its said committee and by Dr. McCormack, to determine whether the said American School of Osteopathy was a reputable medical college within the statutory meaning of the term as above set forth, were conducted openly and fairly and not arbitrarily and capriciously; that the said Board, after a full and complete and exhaustive investigation, determined that the American School of Osteopathy at Kirksville, Mo., from which the plaintiff holds a diploma, was not a reputable medical college.

The plaintiff, Dr. Nelson, testifies that osteopathy cures all diseases except cancer, syphilis and consumption; that he treats Bright's disease and diabetes by manipulation, stimulating the "renic splanchnic;" that he treats diphtheria by manipulations, stimulating the vasomotor center in the back of the neck, and by putting the finger down the throat of a patient and manipulating the soft palate or fauces; that the treatment of scarlet fever, lockjaw, milk leg, varicose veins, dropsy, retention of the urine, piles, fistula in the rectum, and fissure, acute rheumatism, hipjoint disease, simple, benignant

and malignant tumor, chronic syphilis, eczema, shingles, carbuncles, bone felons, bruises, puerperal convulsions, flooding after childbirth, laceration of the cornea of the eye, is by manipulation; but he refuses to state how or in what manner this manipulation is applied.

From all the testimony in this case by witnesses for the plaintiff and defendant, it appears that the whole arcana of osteopathy, in a nutshell, is manipulation-massage.

From the testimony in the case, which I have gone over accurately, it is my opinion, that as a matter of fact the American School of Osteopathy at Kirksville, Mo., is not a reputable medical college; and that the defendant in this action, the State Board of Health, has simply performed its duty in refusing to recognize the said school or its diploma, and to license its disciples or graduates to practice their art in this State.

Out of forty-four States in the Union, it appears in evidence that only four or five States have authorized or allowed the disciples of osteopathy to practice their calling within their borders. In every State the right of an osteopath to practice his calling must depend on the statute of the particular State. In Missouri, where the American School of Osteopathy is chartered, it is enacted by statute that the laws applicable to medicine and surgery do not apply to them; and the testimony of the plaintiff's witnesses in this case shows that they do not teach nor profess to teach medicine and surgery in the American School of Osteopathy. How can it be called a reputable medical college, when its own professors repudiate and refuse to teach materia medica, and therapeutics, and chemistry, and anatomy, and physiology, and confine themselves alone to manipulation? Like the Rosicrucians of the seventeenth century, osteopathy claims to possess a secret gift or method of manipulation, which their witnesses testify cannot be learned from books, by which, however, they claim they can heal the sick. Their professors on the stand refuse to divulge what their methods or modes of manipulatory treatment are. Sorcerers and witches used love philters, incantations and magic talismans for healing the sick, but refused to divulge what the ingredients were, or how the talisman acted.

It is singular, indeed, that in an enlightened age like this such humbug schools and ignorant pretenders could find recognition by the laws of any State.

Let the injunction be dissolved and the petition dismissed.

(*Journal A. M. A.*, Jan. 13, 1900.) STERLING B. TONEY, *Judge.*

We have here only reproduced sections of the case, but even then it is readily seen that a great deal of time and money have been expended by both sides in their efforts to obtain a favorable verdict. In extending our congratulations to the State Board of Health of Kentucky for their success in winning this suit, we do not do so with the intention of gloating over the unsuccessful plaintiff—we do so because they are right, and because we admire them for their courage in upholding a healthy medical curriculum and exposing and prosecuting charlatanry and ignorance.

The kernel in the nut is simply this: "Osteopathy" is nothing more nor less than massage. Massage, in some form or another, has been known and used as an agent in the treatment of disease

since the earliest days of medical history. It can be intelligently administered, and is then of undoubted value in certain well-selected cases; given haphazard, it is positively dangerous. The administration of the dose and the dose itself must be as carefully weighed and proportioned to the individual case as a dose of morphin or calomel, and the masseur or "osteopath" (they being one and the same) is the dispenser of this dose. The intelligent masseur, like the pharmacist, dispenses according to the doctor's prescription, and is a well-recognized factor in the therapeutic armamentarium of the intelligent physician; whereas the osteopath, without knowledge of the science of disease, makes his own diagnosis and applies his treatment — massage. This is given whether the patient has measles, scarlet fever or diphtheria, appendicitis, typhoid fever or hernia cerebri. There are only three diseases (according to their vociferations) that these people cannot cure—syphilis, consumption and cancer. Cosmetic reasons and the danger of self-inoculation may account for their professed inability to cure syphilis, and as for cancer and consumption they show a degree of honesty which is as compatible with this virtue as their countless other professions. We know something of massage in general, as well as most of the methods and movements, and we prescribe it most liberally, but we repeat that the dose must be carefully regulated to the needs of the case; if this is not done, positive harm may result. Massage is therefore not applicable in the treatment of typhoid fever, diphtheria and appendicitis, etc., etc., as the osteopaths claim. Such claims being a delusion and a snare to entrap the unwary and afflicted, it is but meet to congratulate Judge Toney for his manly verdict, and the State Board of Health of Kentucky for their courage and for their success. We also desire to throw a bouquet at Governor Candler of Georgia, who has just vetoed a bill passed by both houses of the State Legislature favoring these charlatans and impostors parading under the name of "osteopaths." More power to you, Governor!

In extending these congratulations, we have only to express one regret — viz.: that it was not Tennessee instead of Kentucky that set the good example. We therefore can only conclude with the hope that Tennessee and all other States will take unto themselves the lesson taught by Kentucky and by Governor Candler of Georgia and do their full duty. Now is the time. M. G.

REPORTS OF SOCIETIES.

PROCEEDINGS OF THE MEMPHIS MEDICAL SOCIETY.

Regular Meeting, January 2, 1900.

The President, Dr. Ellett, in the Chair.

Present were, Drs. Williams, Holder, Alfred Moore, Rudisill, Barton, Griswold, Crofford, Goltman, and Ellett.

Visitor, Dr. Geo. E. Pettey.

The President read a paper on *Fibrous Tumors of the Naso-pharynx, with Cases, Specimens, and a New Snare Attachment.* The cases were two in number.

I. Fibroma of the naso-pharynx. The patient was a boy aged 16, with a fibrous tumor filling the pharynx and both nares. A snare was put on and part of the growth slowly cut through, eight days being required to do it. Later, after preliminary tracheotomy, an attempt was made to withdraw the nasal portions into the pharynx and remove the growth by a snare, but this was abandoned on account of terrific hemorrhage. The final operation was done by Dr. John Maury, who, after preliminary tracheotomy, removed the left superior maxilla and then the tumor. The patient died. The symptomatology, pathology and treatment were extensively considered.

II. A cystic myxo-chondroma of the naso-pharynx. A young lady of 17 complained of impaired voice resonance and nasal obstruction. A pear-shaped tumor was found attached to the posterior end of the left inferior turbinated body and removed with the cold snare, after several unsuccessful attempts. There were also mulberry-like posterior hypertrophies of both inferior turbinals. No bleeding occurred. The recovery was good and there has been no recurrence.

The snare attachment is a small windlass which fits over the end of the straight canula of a snare. The ends of the wire pass through a hole in the shaft of the windlass, and by turning this the loop is tightened. It is lighter than the ordinary snare handle, and can be left in place when it is necessary to cut the tissue through slowly. It also draws the wire straight out, and not on an angle, as many snare handles do.

Dr. Alfred Moore had seen Dr. Rogers operate on a case somewhat similar to the first case reported. The patient was a middle-aged negress, and recovered.

Dr. F. D. Smythe mentioned the details of another such case operated on by Dr. Rogers, to which the essayist had referred. After tracheotomy the tumor was engaged with a snare, the wire breaking repeatedly. A strong cord was then passed around it, twisted tight, the tumor cut off with scissors, and the removal completed with a curette. Hemorrhage was profuse, necessitating packing. Shock was great, but the patient finally recovered. If he met with such a case he would attack it after removal of the maxilla.

Dr. Smythe read *A Brief Resumé of Cases Operated at City Hospital During Three Months Service.* Thirty-six cases were reported, comprising fibroid tumors, lithotomy, cholecystotomy, appendicitis, hernia, amputations, arthrectomy, circumcision, urethral stricture, enlarged glands, etc. Two deaths occurred in the series.

Dr. W. C. Griswold asked Dr. Smythe if he preferred suprapubic to perineal lithotomy.

Dr. J. L. Barton asked if he advocated the removal of syphilitic buboes.

Dr. Alfred Moore thought removing instead of incising suppurating glands was good practice. He asked Dr. Smythe if he advised amputation in cases of incurable leg ulcers, and what did he term incurable cases. He had seen necrotomy in these cases yield good results.

The President asked if Dr. Smythe really meant that the petrous portion of the temporal bone was necrosed in the case of supra-auricular abscess which he reported.

Dr. M. Goltman asked what was the condition of the medulla of the bones above the line of amputation in the ulcer cases.

Dr. Edwin Williams asked if fibroids are more common in negro women than white, and why.

Dr. T. J. Crofford said more hard fibromas were seen in negroes than whites, and as a rule they are accompanied by diseased appendages. It is probably to the nutritive changes accompanying the diseased appendages that the fibroids are due.

Dr. Smythe said that in syphilis there is no bubo (suppurative) unless there is mixed infection, in which case he removes the glands;

chronic leg ulcers are hardly ever susceptible of cure, but temporary improvement only. The medullary cavities were so affected in some cases as to necessitate going above the joint (knee), and then in two cases that of the femur was far from healthy. He favors suprapubic cystotomy as easier—no opening is left, the prostate is not injured, there is no danger of causing impotency, and large stones cannot be removed by the perineal method. In some old cases, which are to be drained, it is best to do the operation in two steps, and drain over a granulating surface which does not readily absorb pus, etc. The fibroids were mostly in negroes. In four the ovaries were diseased. In one case, one ovary was left, after puncturing two small cysts, the other being removed.

Regular Meeting, January 16, 1900.

The President, Dr. E. C. Ellett, in the Chair.

Present were, Drs. R. H. Mitchell, McKinney, Barton, Crofford, Buford, Reilly, Alfred Moore, Ellett, Williams, Krauss, Griswold, F. A. Jones and Haynes.

Dr. Richmond McKinney read a paper on *The Treatment of Deviated Nasal Septa.* This condition is present in 75 per cent. of all cases, and is due to traumatism in infancy. The deviation may be single or sigmoid, and affect the cartilage, bone, or both. Symptoms are usually due to deflection of the cartilaginous portion. The Asch operation is preferred, and was described. Briefly the operation consists in making cross cuts through the septum, freely mobilizing the fragments and holding them in place by tubular splints till healed—i.e., about five weeks or more. The writer prefers to use local anesthesia, and in five cases has had four good results.

Dr. F. A. Jones saw two of Dr. McKinney's cases, one being very bad, the nasal obstruction interfering a good deal with the patient's health, which was much improved by the operation.

Dr. G. G. Buford asked if adenoids and other causes of nasal obstruction might not cause deflection of the septum.

The President has had some experience with the Asch operation, and more with the older methods of operating, which he found unsatisfactory. Trimming off the convexity of the septum does not as a rule restore nasal breathing. He has recently removed the whole inferior turbinated body from the obstructed side of a patient

who declined the Asch operation, and the result was very good. Thorner has recently called attention to the fact that not only is breathing restored, but often a crooked nose is made straight by putting the septum back in the median line. As regards the anesthetic, general anesthesia permits free manipulation and a more thorough operation, and he prefers it in all nasal operations as severe as this.

Dr. McKinney said that adenoids, etc., might act as a cause of deflected septum. He has found cocain anesthesia satisfactory, and it is easier to operate with the patient sitting up and assisting your efforts.

Dr. F. A. Jones read a paper on *Rectal Lesions as Seen in the Negro.* Mathews says that hemorrhoids are rare in the negro, but the writer finds them very common and more aggravated, as a rule, than in the white. The negro eats a diet which taxes his digestive apparatus, produces congestion and therefore hemorrhoids. Stricture of the rectum is common and usually syphilitic. In twenty-one cases, twenty were in females, and the one in the male maligant. Surgical treatment is the only one of value in strictures. Fistula in ano is common in negro men, and usually occurs in tubercular subjects. Pruritus ani and seat worms are common. The latter may cause vulvo-vaginitis. Proctitis and chronic diarrhea are common. Colitis is rare.

Dr. J. L. Barton asked if cancer of the uterus was seen in the negro or mulatto. He had not seen it in the former.

Dr. T. J. Crofford said in the last three weeks he had seen three cases of cancer of the uterus in negro women, and each year sees two or three.

Dr. W. C. Griswold has had a similar experience, and thinks cancer and other tumors and hemorrhoids common in the negro.

Dr. J. H. Reilly thinks the experience of these gentlemen should be put on record, as it is at variance with that of other observers.

Dr. G. G. Buford has seen cancer of the uterus frequently in negro women. In his pension work he has examined 3000 or 4000 negro men and has seen very many cases of hemorrhoids, but only three or four of rectal stricture. The applicants are old, and possibly those with stricture do not live to be old.

Dr. Alfred Moore asked if the diagnosis in the cases thought to be malignant had been verified with the microscope.

Dr. Crofford relies, in cancer of the uterus, on the clinical and macroscopic features for diagnosis. In late cases degenerative changes obscure the histologic picture.

Dr. Jones agrees with Dr. Crofford on this point.

Dr. J. H. Reilly mentioned a case in which a diagnosis of cancer of the cervix was made and operation advised, and the microscope showed the changes to be degenerative only. The value of reports is enhanced by including microscopic findings.

Dr. Crofford mentioned an opposite case, where a growth pronounced benign by a competent microscopist turned out to be malignant.

Dr. Buford presented photographs of a case of elephantiasis of the scrotum. (To be published in the Memphis LANCET.)

Dr. R. H. Mitchell reported a *Case of Puerperal Eclampsia.* The patient was a primipara aged 16 and had been delivered by a midwife. He saw her after the child was born, placenta undelivered, and the patient in convulsions. Chloroform was used to arrest the convulsions, twenty grains of chloral and ten drops of veratrum viride and two drops of croton oil given. Hypodermoclysis was also used. The patient had a small, hard, rapid pulse, and bleeding was therefore not advisable. The kidneys were inactive. Diaphoresis was induced, and the bowels moved from the croton oil and salts, but the convulsions were not arrested and the patient died in fifty-six hours. This is the second fatal case he has seen in two months. The mortality is 20 to 30 per cent.

Dr. Barton has seen some cases occurring ante-partum and relieved by inducing labor.

Dr. Buford has seen three cases, all of which were bled and all recovered. In one case this was the only treatment used.

Dr. Reilly has recently seen a case occurring at the seventh month of pregnancy. In spite of bleeding, saline transfusion and the induction of labor, the woman died.

Dr. Mitchell said death was due to retained toxins and not to hemorrhage.

Dr. Wm. Krauss suggested, on theoretical grounds, bromide of potash, to decompose the toxins and form soluble carbamid, which is more easily eliminated.

Dr. E. E. Haynes has had four cases with two deaths. The plethoric cases, with high tension pulse, are suitable for bleeding, and

these patients are much more apt to get well than the anemic, illy-nourished ones. In his last case the convulsions did not begin until a week after delivery, when the patient's nutrition was improved and the blood pressure raised.

Dr. Edwin Williams mentioned continuous rectal irrigation with salt solution in these cases.

Dr. Alfred Moore reported *An Obstetrical Case* in which he had used rubber gloves with such satisfaction that he proposes to use them habitually hereafter.

Dr. F. A. Jones reported a *Case of Parenchymatous Nephritis* with sudden edema and great dyspnea. The patient was sent to the hospital, where tracheotomy was proposed, but the patient died before it could be done.

PROGRESS OF MEDICINE.

Vaginal Celiotomy.—The *Alabama Medical and Surgical Age* abstracts A. Lapthorn Smith's article from the *American Journal of Obstetrics*. He had operated eleven times by the vaginal route, concluding that—

1. Vaginal celiotomy is indicated in retroversion with fixation, in minor diseases of the ovaries and tubes, and in small fibroid tumors of the uterus. But in the author's experience the vaginal method of freeing the retroverted adherent uterus is, on the average, more difficult than the abdominal method, and vaginal fixation is not so reliable in curing the retroversion as is ventrofixation.

2. If the uterus be movable and there are no adhesions to be broken up, one is not justified in opening the peritoneal cavity, either by the abdomen or the vagina, in order to shorten the round ligaments. In such cases Alexander's operation is easy, quick, safe and more reliable. The author has had no failures in his last one hundred cases.

3. For the removal of pus tubes the operation by the vagina is more difficult than by the abdomen in all cases excepting those in which the uterus is removed at the same time. When the uterus is split in half and each half is removed with its corresponding ovary and tube, when clamps are used, the vaginal operation is

easier than the abdominal, in which ligatures are employed. The vaginal operation is a little safer on account of the drainage which it affords, but on the other hand it offers more risk of injuring the ureter. The author is opposed to the removal of the uterus, even when both ovaries and tubes have been removed, owing to the bad moral and physical results; and he is opposed to the use of clamps as compared with ligatures, because, although easier and quicker, the clamps prolong the convalescence, owing to the bruising of the nerves in the broad ligaments.

4. For the removal of chronically-inflamed ovaries and tubes, vaginal celiotomy has the following decided advantages:

a. It is less dangerous, because the intestines are not exposed to the air, or to bruising by the hands, or to infection through diseased tissues passing over them so much as when the latter are removed by the abdomen.

b. Vaginal celiotomy is less painful, the incision in the vagina causing almost no pain, while the abdominal incision and stitching are exceedingly painful. In vaginal celiotomy morphin is rarely required; in abdominal celiotomy it is cruel to deprive the patient of it, although we know that her convalescence is prolonged by its use.

c. There is no telltale scar after vaginal celiotomy, which is sometimes a matter of great moment to young single women who intend to marry. The presence of the scar has to be explained, and the patient is suspected of having been unfitted for marriage by the removal of both ovaries, when in reality one or both of the ovaries remain.

d. The danger of hernia, although the author has had no case of hernia during the last three years, owing to his method of suturing and leaving in the silkwormgut either permanently or at least a month, and he considers this accident entirely preventable, yet for those who meet with it, its possibility should have great weight in balancing the merits of the two operations. There is no hernia after vaginal celiotomy.

5. Much good conservative work on the ovaries and tubes, and even on the uterus, can be performed by vaginal celiotomy with almost no pain or risk to the patient. The uterus and appendages can be brought out at the vulva through an opening in the anterior vaginal wall, and cysts can be excised or burned out; one-half of one ovary can be amputated and the remaining bivalvular flaps

neatly brought together with fine silk or catgut; the closed tubes can be opened, or a piece of the pavilion removed, and a probe passed into the uterus, and the mucous and peritoneal layers of the remainder of the tube brought together with interrupted catgut sutures; and the small fibroids, not larger than the normal uterus itself, can be cut out and the hole in the wall of the uterus closed with two or three rows of fine sutures. But it is very dangerous to open up closed tubes as long as there is any active inflammation or infection going on, because by so doing we break down the wall of defense made by nature around the infected tubes to save the general peritoneal cavity from invasion.

6. Tubal pregnancy, before rupture and not later than the sixth or eighth week, can be readily removed by vaginal celiotomy; the author had one successful case as compared with twelve successful cases by the abdomen. But vaginal celiotomy is contraindicated when the pregnancy has advanced to twelve weeks, or has ruptured into the abdomen. In several of the author's cases the vermiform appendix was diseased and adherent to the tube, for the removal of which abdominal celiotomy was essential. In several other of the author's cases the abdomen was full of clots as high up as the liver, and the fetus was floating among the bowels higher than the umbilicus; these cases could not have been successfully operated on by the vagina.

7. In general terms, all cases in which the trouble is small in size and located low down, can and should be operated on by vaginal celiotomy, while everything large and located high up, should be reserved for abdominal section.

Cancer of the Uterus and Its Early Diagnosis.—The *Medical Record*, December 9, 1899, gives the following abstract of a paper read by Dr. Thos. S. Cullen before the Medical Society of the County of New York:

He said that there were three different kinds of mucous membrane in the uterus, viz.: (1) that of the vaginal portion; (2) that of the cervix; (3) that of the body; and hence there were three definite varieties of carcinoma, and only three, in the uterus. His object in coming here at this time was to try and impress upon those present that there was no difficulty in making a diagnosis of carcinoma of the various portions by an examination of the scrapings.

A number of excellent plates were exhibited in order to give a proper conception of the histology of the normal uterus. The presence of glands at a considerable distance from the mucosa was not, as had been supposed by some, an indication of malignancy. An idea that had gained quite general acceptance, was that the mucous membrane of the uterus was shed at each menstrual period, but some recent studies had shown that such was not the case. Plates were exhibited showing one very characteristic appearance of carcinoma of the cervix, viz., myriads of minute finger-like processes. One of the plates presented demonstrated conclusively that the glands in the body of the uterus took no part whatever in squamous carcinoma of the cervix. Rarely in cancer of the cervix was there an extension into the lymphatic glands. The cells in cancer of the cervix were usually rather large, and the lymph radicles rather small. In the breast, on the other hand, there were small epithelial cells and large lymph channels. It was probable that the growth must extend far out into the broad ligament before extension into the lymphatic glands could take place. In one case, in which there was a squamous carcinoma of the cervix associated with pregnancy, the woman had been kept under observation until term, and then both uterus and child were removed. The child had lived four or five months, and had then succumbed to some intercurrent trouble. The mother was still alive and well, though the operation had been done two years ago. A very curious and interesting feature of the case had been the presence of a normal decidua formed on the lip of the external os, as well as in the uterus. In one case, in which a diagnosis of malignancy had been made from an examination of the scrapings, after removal of the uterus it had been impossible even for an expert to distinguish, from the external appearance, between this and the normal uterus. However, on cutting open the uterus, a malignant growth had been found. In such a case diagnosis without microscopic examination would have been impossible. The glandular growth of the cervix, the speaker said, was the most malignant type of carcinoma found in the uterus. True erosion of the cervix was characterized by loss of substance and disappearance of the epithelium, but a large number of so-called erosions were nothing more than eversions of the normal mucous membrane. As the blood vessels in this portion of the mucous membrane were covered only with a layer of epithelium the surface appeared red.

When such a surface was treated, as in the old days, by repeated application of iodine, the result was a thickening of the epithelial covering and an appearance resembling healing of the surface, so that it looked like the outer portion of the cervix. This had led the physician to suppose that the "erosion" had been healed; but in a few weeks the thickened epithelium would be exfoliated, the blood vessels would once more show through the thin epithelium, and the physician was then led to believe that the "erosion" had returned. Occasionally the hardening and dilating of the glands of the cervix would give an appearance suspiciously like carcinoma. In cases of adeno-carcinoma of the body of the uterus it was impossible to say definitely, by palpation, that malignant disease was present; indeed, such might be the case and still the uterus be diminished, rather than increased in size. In this class of cases one must depend upon microscopic examination for a diagnosis. In all cases in which the patient was between thirty and sixty years of age, and there were hemorrhages, and the diagnosis was not clear, the uterus should be curetted or a portion of the cervix removed. The diagnosis of malignancy having been made, no time should be lost in removing the entire uterus. It should not be forgotten that in securing the scrapings the curette must be systematically applied to the whole interior of the organ, otherwise the diseased portion might be passed by.

The Appendicitis Question Again. — "To operate, or not to operate, in appendicitis" is still one of the absorbing questions of the hour. The physician proper still leans favorably to the expectant plan of treatment, while the operator urges removal of the appendix in all cases as being the only method of cure. The surgeon, however, weighs the pros and cons for operation in each case, and governs his actions accordingly. Of course each patient, and every attack of appendicitis, must be considered as an entity, and no steadfast rules can be set down to govern all cases. Certain clinical facts have been demonstrated so often in the course of this affection that broad lines of action may be formulated upon them. Briefly stated these are as follows:

1. As we can never tell from the nature of a previous attack of appendicitis what will be the character of the next seizure, or when, if ever, it will occur, a patient who has had one mild attack

should have this clinical observation clearly stated to him, and the decision for or against operation left with him. If a patient has had more than one attack, the probability of a recurrence is much stronger, and the surgeon may even urge an operation in the interval, the burden of responsibility, in case of refusal, being placed upon the shoulders of the patient. Under this head belong all those cases in which, after the subsidence of the acute seizure, the parts apparently return to their normal condition. Should adhesions of the appendix to neighboring structures have occurred, which in themselves cause pain and interference with the general well-being of the individual, there would exist a further indication for surgical interference.

2. If, during the course of an acute inflammation of the appendix, there is manifested a distinct tendency to a regression, we may safely wait for the subsidence of the attack, and then consider the patient as outlined above. Such regression is determined by careful observation of the triad of symptoms, which in relative importance are: (*a*) Pulse rate; (*b*) local pain and rigidity of the abdominal muscles; (*c*) temperature elevation. If the pulse rate steadily declines and the other two symptoms become less marked, the inflammation is regressing, and operative attack can be deferred.

3. But if there is a distinct progression as indicated by an increasing rapidity of the pulse, and more marked local pain and rigidity, irrespective of temperature elevation, operation is urgently demanded.

4. Abscess cavities call for immediate careful evacuation.

5. General peritonitis demands immediate operative interference, except when the general condition of the patient forbids a formidable procedure. Such latter patients do better if treated expectantly, and often enough these desperate cases improve, and then their subsequent surgical treatment depends upon the local condition.

These general principles of action will be found to govern the vast majority of cases. But one must never forget that appendicitis does not always run a typical course, and in the atypical cases the internist and the surgeon both must rely on their past experiences to enable them to decide for or against operation.—*Editorial in Medical Record*, December 30, 1899.

The Pathology of Lobar Pneumonia as a Basis for Treatment. Dr. Andrew H. Smith read a paper before the N. Y. Academy of Medicine, Nov. 2, 1899, on this subject. In using the term "pneumonia" he said that he desired to restrict it to the form variously designated as lobar, fibrinous, or croupous, the form which, in typical cases, was ushered in abruptly by chill and fever, and which, after from four to nine days, if the patient was to recover, ended suddenly by crisis. Pneumonia, he said, was not an inflammation of the lung, although pneumonitis could be produced at will in one of a great many ways. Inflammation, suppuration, and even gangrene might be produced, but it would not be pneumonia. There was one thing which introduced into the parenchyma of the lung would always produce pneumonia, and that was the pneumococcus. These facts served to differentiate sharply between pulmonary inflammation and pneumonia. It was not enough to admit the infectious nature of the disease and define pneumonia as an inflammation excited by the presence of a specific parasite. The parasite was unquestionably there, but it did not excite an inflammation. In pneumonia the parenchyma of the lung did not suffer; at most there was a certain amount of desquamation of the epithelium. There was nothing left to represent the results of inflammation. The tremendously active process that had gone on in the lung vanished, and left no trace behind it. For this we had to thank the special nutrient circulation provided by nature. At the same time, and in the same area, one could see the action of the right heart completely suspended, and that of the left heart going on actively. In the pneumonic lung, the capillaries which were the continuations of the pulmonary artery were completely thrombrosed, and this thrombosis extended back to the heart. If the entire lung were involved the thrombosis would extend back into the bifurcation of the pulmonary artery. The blood supply from the bronchial arteries, on the other hand, was completely free from obstruction. In pneumonia we had to deal with a process of germ culture going on in a culture medium, each air cell acting as a tiny test tube, and filled with this culture medium. The complicated manifestations completing the clinical picture of pneumonia were epiphenomena. Two of these epiphenomena were of extreme importance, constituting singly, or together, the chief menace of life, viz.: (1) Infection of the system by toxins formed in the lung, and (2) the embarrassment of the lungs

from the exudation in the air cells. From the first arose a host of manifestations dependent upon toxemia; from the second, we had the ever present danger of failure of the right heart.

Treatment. Heretofore the treatment of pneumonia had been far from satisfactory, pneumonia destroying more lives than any two other acute diseases put together. Within the past decade, however, there had seemed to be the dawning of a better era. The problem before us was first of all to arrest or inhibit the growth of the pneumococcus, bearing in mind the peculiarities of the organ in which the disease process took place. It should be remembered that the life of the organism was short, not exceeding ten or twelve days in artificial cultures. Another interesting fact was, that this was one of the most sensitive of all germs, its growth being arrested by very slight changes in its surroundings. If we could impregnate the blood sufficiently with a substance inimical to the growth of the pneumococcus, there would be a chance of forestalling the local process. The local process was always a spreading one, so that it seemed perfectly feasible to prevent the spread of it to other cells than those first invaded. Long before the microbic theory of pneumonia had been understood, or even thought of, calomel had been a favorite remedy, although given with the idea that it was an antiplastic. The older practitioners rarely had the hardihood to treat a case of pneumonia without a mercurial. In 1878 Dr. Mary Putnam Jacobi had reported the result of an investigation into the action of the so-called "sedative dose" of calomel in pneumonia. The results from this treatment, which had been a favorite one with the late Dr. Leaming, had been quite remarkable. Quinin, though a feeble antagonist to other than malarial germs, was known to have a decidedly beneficial action in pneumonia when given in rather large doses. This was not surprising when one considered how thoroughly this remedy pervaded the whole system. Dr. J. S. Thacher, at his suggestion, had made a number of experiments in the laboratory of the Presbyterian Hospital, regarding the effect of chloroform on the pneumococcus, and these had abundantly substantiated what had long been known from clinical observation concerning its powerful influence in pneumonia. Creosote had been highly lauded by a number of observers as a useful remedy in pneumonia. It had been given by the mouth and in enemas. The carbonate of creosote had been found to saturate the blood readily

without irritating the stomach, and without giving rise to poisonous or other untoward effects. A very remarkable series of twenty-two cases of pneumonia occurring in Austria among miners had been reported. All of these had been treated with large doses of sodium salicylate—gr. cxx daily. All of these patients had recovered, and in not one had the disease terminated by crisis.—*Medical Record*, November 18, 1899.

A Method of Treatment for the Restoration of Entire Tibiæ, Necrotic from Acute Osteomyelitis.—Cushing (*Annals of Surgery*, October, 1899) reports an instructive case in which he was able to restore the entire tibia after an acute osteomyelitis. The method employed is described by his summary as follows:

The indications are: To save the patient's life, relieve pain, and by immediate operation to establish free drainage. The medullary cavity should be opened, pressure relieved, and infection checked. If the bone is killed, as it usually and rapidly is in a few days, it should be removed. The most favorable time for its removal is when the periosteum and granulation tissue are in their most active generative stage, but before the process of calcification of the bone trabeculæ has shut the sequestrum within the compact, dense shell of involucrum. This point is to be determined by frequent examinations of sections of the periosteum with the microscope. It is shown by the presence of numerous fibroblasts, osteoblasts, and small trabeculæ in which lime salts are beginning to be deposited. Clinically, it can be recognized by the slight crackling sensation as the periosteum is incised, due probably, to the crushing of the trabeculæ by the knife. The periosteum at this stage resembles granulation tissue in color, density, and vascularity. There is no macroscopical appearance of ossification. Bone will be formed from this elastic, flexible periosteal layer.

This stage in this case was probably reached in the seventh or eighth week of the disease. At this stage the necrotic bone should be removed by incising the periosteum in the long axis of the leg and shelling out the sequestrum. The periosteal sheath remaining should be closed by suture, leaving a solid cord or mass of periosteum buried in the center of the leg when in its most active bone-producing condition. If areas of calcification of any extent or thickness are found adherent to the inner surface of the periosteal sheath, they

should be dissected off. The soft parts and skin superjacent can be closed by suture. The utmost care and most efficient means should be used to render the operation an aseptic one, for primary union is important. The new bone is formed rapidly, apparently in eighteen or twenty-four hours, when the operation is done at the time above indicated. At this time ossification is so advanced that the new bone is rigid. If the operation is done too early the periosteum is injured, apparently, and its growth interfered with. If too late, a rigid, bony involucrum makes the removal of the sequestrum more difficult and forms a cavity which is very difficult to close. It is demonstrated by the radiograph that the medullary cavity is re-formed in the new bone. The shaft of the bone is easier to restore than the epiphysis.—*Am. Jour. Med. Sciences*, Jan., 1900.

The Widal Reaction in Tuberculosis.—S. H. von Ruck (*Journal of Tuberculosis*, Oct., 1899) in some sixty tests of the Widal reaction in four classes of cases, viz.:

1. Blood from well-marked typhoid;
2. Blood of patients not having nor having had either typhoid or tuberculosis;
3. Blood of tubercular patients who never had typhoid;
4. Blood of tubercular patients with a previous history of typhoid;—

obtained the following results:

With the typhoid blood a complete reaction occurred in fifteen minutes.

In cases of those who never had typhoid nor tuberculosis there was no sign of reaction in the first fifteen minutes. The clumps which formed later were all very small, and in none of them, even after an hour, was there cessation of motion; while in the vast majority of bacilli which remained free in the field, motility continued more or less active.

With the blood of tubercular patients who never had typhoid modified reactions were obtained. The reaction began to take place within fifteen minutes but was more complete in less than an hour.

In the cases of tubercular patients with a past history of typhoid a modified reaction was obtained, more pronounced the more recent the typhoid.

From the results of the experiments above recorded the author concludes:

1. Inasmuch as with the blood of tubercular patients who had never had typhoid fever a modified reaction was obtained; and as no reaction occurred with the blood of individuals free from tubercular infection and with no previous history of typhoid; it may not be unreasonable to presume that such change takes place in the blood of the former, not occurring in that of the latter, which in a manner exerts a certain degree of protective influence against infection with the Eberth bacillus.

2. A true Widal reaction is not to be obtained with the blood of tubercular patients; but what may be termed a modified reaction does occur quite uniformly, the difference being one of time and degree only.

3. The modified reaction seen with the blood of persons suffering from tuberculosis in no way detracts from the value of the Widal reaction as applied in typhoid fever. However, the results shown should, in the use of this diagnostic means for typhoid, lead those to be cautious who are not familiar with what constitutes a true Widal reaction.

Report of a Few Cases of Chronic Empyema of the Antrum of Highmorè—Operation by Caldwell-Luc Method.—A. W. De-Roaldes (*N. Y. Med. Jour.*, Jan. 6, 1900) reports five cases as above. In making a diagnosis of antral empyema he relies on the trans-illumination test by Heryng's lamp. Treatment of chronic antral empyema has been very unsatisfactory, and this operation devised by Dr. Geo. W. Caldwell, of New York, and popularized by Dr. H. Luc, of Paris, promises better results. The object is to make a free opening into the nose, and not to leave any opening between the antrum and the mouth.

The technique of the operation was carried out as follows:

The patient having been chloroformed, the inferior turbinate body of the affected side was attacked with a cutting forceps and its anterior third removed, after which the nasal fossa was firmly packed with gauze and attention turned to the opening of the antral cavity through the canine fossa. The upper lip being everted and well retracted by an assistant, the incision was made through the soft parts, beginning just below the gingivolabial fold near the

frenum anteriorly and extending posteriorly in a horizontal direction back to the root of the first molar tooth. The periosteum was included in the incision and both flaps were detached from the bone and retracted so that the bony anterior wall was laid bare. A chisel was then used to make an opening into the cavity at the deepest point in the canine fossa, and by means of bone forceps this opening was enlarged so that the finger could be readily introduced and extended anteriorly almost to the nasal process of the maxilla. This gave free access to the cavity for the introduction of instruments and inspection with the eye and finger. The antrum was found to be lined within by a thick growth of polypoid tissue that almost obliterated its cavity. Quite a free hemorrhage occurred at the stage where the antrum was opened and this tissue attacked with a curette; but firm pressure by means of a gauze pack quickly checked the flow, and the scraping was systematically continued until the cavity had been deprived of all its interior lining and nothing remained except the bare bony walls. This done, a temporary gauze pack was introduced into the cavity and the drainage way into the nose established as follows:

The pack removed from the nose, a finger was introduced and placed upon that part of the antral wall corresponding to the resected part of the turbinate. With this as a guide, a chisel was placed upon the corresponding point on the side of the cavity and used to break away a part of the bony wall, the opening being made sufficiently large to permit of the free passage of the finger. Any remaining shreds of mucous membrane left on the nasal side were cut away with a biting forceps, so that the artificial hiatus thus made would be in nowise obstructed.

It only remained now to suture over the wound made in the canine fossa and cut off all communication from the mouth. With the lips well retracted and a properly-curved strong needle employed no very great difficulty was experienced in carrying out this step of the procedure. Rather fine catgut was employed in interrupted suture, the mucous membrane and the periosteum being caught up together and brought into firm apposition over the breach in the bony wall. Before the cavity was finally closed, however, the gauze packing was removed, iodoform powder insufflated, and a fresh strip introduced through the nose, so as to avoid any difficulty in its removal at the first dressing a few days later.

On account of the bleeding it is advisable to defer the turbinotomy till the last step of the operation. Cure follows this treatment in four to six weeks.

The Present Status of Cancer, and Our Duty Toward its Victims, is the title of the presidential address delivered by McGannon before the Middle Tennessee Medical Society (*Medical and Surgical Bulletin*, December, 1899). Faith in the parasitic theory of cancer is based upon the following summary of the results already made:

1. The existence of certain bodies in cancer tissues, these being found both in the cells and outside of them.

2. They are found in the active, growing part of the tumor, and not due to degeneration.

3. Cancer is the only neoplasm in which they are found.

4. They take stains entirely different from the other elements of the growth.

5. These bodies have been isolated, and grow in culture media. They have also been modified by passing through animals, and have again been transferred to suitable living animal tissue, and have produced a disease with the characteristics of cancer.

6. They are transferable by inoculation, as shown by divers reports of cases of accidental and intentional transference from one situation to another in the same individual, and from one individual to another.

7. Occurrence in families, usually attributed to heredity, but which may be due to environment and to the contagiousness of the disease.

8. The existence of epidemics, as reported by various observers, can only be explained by infection.

9. Cancer houses, so called—that is, dwellings in which cancer has been observed to occur independent of the families occupying them, thus removing the theory of heredity.

Certain well-demonstrated facts in regard to the origin of cancer must still be recognized—the first of which is *age;* this usually begins with the time that the body cells begin to deteriorate more than they develop—i. e., between 35 and 40 years; developmental organs, as the mamma and uterus, are the favored sites. The second is *traumatism;* this is most probably incidental as a cause. The

third is *climate* and *locality;* low and wet lands seem to favor the death rate from cancer. The fourth factor is *prolonged irritation*, and the author lays much stress on the prolonged irritation of unrepaired cervices, and advises that every means be employed to secure an early diagnosis, as only in that stage, when the disease is local, can a cure be effected.

The microscopic examination of curettings is open to serious error, as these may not contain any of the suspicious tissue. Clippings from the affected area should be taken.

As to cancer being on the increase, the author is of the opinion that this is to a great extent apparent; so many quacks treat as cancer any sort of granuloma, and the cures effected by faith healers and such gentry cannot by any possibility have been cancer. Instances are related showing the frequency of unrecognized cancer in the practice of some physicians whose cases are diagnosed too late for radical relief, which puts operation in disrepute among the laity.

The Principles of the Treatment of Fractures by Systematic Movements and Massage Without Apparatus for Immobilization. Lucas-Championnière (*Med. News*, Jan. 6, 1900) says that moderate movement favors the repair of fragments of a bone. Where movement is permitted the callus will be greater in quantity, will be more solid, and will be more rapidly thrown out. Any large amount of movement will inhibit the process of repair, or at least seriously interfere with it. Moderate movement preserves the vitality of the limb and preserves the suppleness of the articulations, the muscles, and the tendons. It entirely prevents the occurrence of any muscular atrophy. In every case, therefore, in which moderate movement does not threaten to cause the occurrence of deformity, the limb should not be immobilized. On the contrary, an attempt should be made to keep up passively if not actively the movements that are necessary to the vitality of the parts.

In addition to this passive movement, massage, which especially favors the repair of traumatic lesions of muscles, tendons, ligaments, and articulations, may always be applied in practice on the single condition that the parts involved in the fracture do not thus become the subject of untimely interference with repair. We may apply massage to fractures immediately after an accident on condition

that this massage be of the special kind that can be performed while the fractured member is properly supported. Massage, if undertaken in the ordinary manner, or if administered too energetically, would certainly result lamentably. The massage for a fracture ought to be applied to all parts of the limb, along the muscles, over the ligaments, and upon the hemorrhagic effusions, but never just over the site of the fracture nor directly upon the fractured ends of the bone. The massage should consist of gentle, repeated pressure always in the same direction from the periphery of the limb toward the trunk. It should be sufficiently prolonged. The length of time spent at massage will depend somewhat upon the character of the lesion and the sensitiveness of the patient, but at least a quarter of an hour to twenty minutes once a day should be devoted to it.

The massage should never give pain. It should always be followed by an attempt at passive movements of the joints of the limb, which procedure must also be accomplished without pain.

Mastoiditis; The Importance of Early Surgical Treatment. McCaw (*N. Y. Med. Journal*, Dec. 30, 1899) says that there are some who advocate a more conservative plan of treatment, but they are greatly in the minority, and the tendency is toward more radical measures. From his clinical experience and the literature of the subject, he is forced to the conclusion that where there is undoubted mastoid involvement the only safety lies in early operation, before the patient passes the border line of safety into the dangerous grounds of meningeal and cerebral complications.

In answer to the question, when shall we interfere surgically? He should say, apply that invariable rule of surgery that wherever there is pus it should be evacuated. His observations, well borne out by the almost universal opinion of the best authorities, prove that sagging of the postero-superior canal wall is indicative of the presence of pus. If that is true, the natural deduction follows that when this condition is present it calls for surgical interference in the patient's behalf.

In mastoiditis following the chronic otorrheas there is no ground for discussion. The only thing left for us to do is to deal with it radically and at the very earliest moment, for it is the danger signal, and if unheeded is sure to lead to disastrous results. For a physician to stand by and wait for the catastrophe of which he has been forewarned is little short of criminal negligence.

Conclusions.

1. In threatened mastoid involvement and in the mild acute cases the conservative plan of treatment should be first tried for at most a week or ten days, unless dangerous symptoms arise.

2. Operative interference should be instituted: (a) in acute cases where there is sagging of the postero-superior canal wall; (b) where the infection is of a virulent nature; and (c) in all cases complicating chronic otorrheas.

Relative Frequency of Iritis in Syphilis and Rheumatism, Observed in Three Thousand Cases.—Brunson (*Ophthal. Record*, November, 1899) found a total of 48 cases of iritis in 1500 cases of syphilis, which is a little more than 3 per cent. of the entire number of cases examined, and a total of 23 cases of iritis in 1500 cases of rheumatism examined, which is about 1½ per cent. of all the cases of rheumatism.

As a general rule we may accept the following table to differentiate between iritis caused by syphilis, and iritis caused by rheumatism:

Rheumatism.

1. History of acute or chronic rheumatism, or some evidences of uricacidemia.
2. Photophobia, lachrymation, and pain well marked.
3. Condylomata never observed on iris.
4. Iris often very bright.
5. Exudative changes slight.
6. Posterior synechiæ long, thin, and not pigmented.
7. Very little tendency to formation of pigment on the anterior capsule of lens.

Syphilis.

1. History of syphilis either acquired or hereditary.
2. Photophobia, lachrymation, and pain not well marked.
3. Condylomata present in every case.
4. Iris often very dull.
5. Exudative changes very extensive.
6. Posterior synechiæ short, broad, and pigmented.
7. Very marked tendency to formation of pigment on anterior capsule of lens.

In his experience with this class of patients, he states that he does not agree with most authorities on the subject in regard to the absence of chorio-retinitis in rheumatism, as he has seen this complication occur many times in rheumatic iritis.

Aseptic Catheterism.—Beck (*Medical News*, Jan. 6, 1900). Catheterism is the most important procedure in the treatment of the genito-urinary tract. As it has the dignity of a surgical operation, it should be viewed from a strictly surgical standpoint and should especially be preceded by the same preliminary precautions, at least in principle. These precautions consist in the sterilization of the instruments, the hands of the surgeon, and the field of operation.

There are three most important virtues required in catheterism: Thorough cleanliness, extreme delicacy, and much patience. The same principles should be upheld if the patients are instructed to catheterize themselves. From a scientific standpoint, the trusting of such a surgical procedure to a layman is to be deplored, and such risky commissions should be resorted to only under the most pressing circumstances. Soft catheters should be chosen, and the fact that their usefulness is soon destroyed by repeated boiling should not be allowed to carry much weight in such a serious consideration.

A Plea for the More Frequent Digital Exploration of the Uterine Cavity.—Wm. E. Swan (*New York Medical Journal*, vol. 70, no. 16) reports two cases of hemorrhage from the uterus due to polypi—one of which had been curetted many times, but the polyp was not found until the uterine cavity was explored with the finger, when it was easily removed with forceps. The other case suffered from profuse menorrhagia and metrorrhagia, for which hysterectomy was performed, under the impression that it was malignant. On incising the organ a small polyp was found to account for the hemorrhages.

Dr. L. L. Meyer, of Memphis, reports a case of an interesting and curious accident. He was called to see a baby four months old, which had been very fretful for several days. An examination revealed that the child's middle toe was swollen, which was due to a human hair wound tightly around it. The hair had cut through the tissues, almost completely amputating the toe. After removal of the hair, recovery was prompt.

BOOK REVIEWS.

Any medical book can be obtained through the Lancet at publisher's prices, postage free. Terms cash. The usual discounts are allowed.

A Manual of the Diagnosis and Treatment of the Diseases of the Eye. By Edward Jackson, A.M., M.D., Emeritus Professor of Diseases of the Eye in the Philadelphia Polyclinic; formerly Chairman of Section on Ophthalmology of the American Medical Association; Member of American Ophthalmological Society; Fellow and Ex-President of the American Academy of Medicine. With 178 illustrations and 2 colored plates. W. B. Saunders, Philadelphia, 1900. Price, $2.50.

At this time a book on diseases of the eye must possess some distinctive feature to warrant its existence. The present volume justifies its publication by being a manual of small size, and probably better adapted to the needs of the student than any other American textbook. Condensation is a dangerous business, but few could say so well so much in a small space. There is little room given to the discussion of theories, but facts are clearly stated in a way to carry the information in a most direct manner. The tone of the whole work is worthy of its distinguished author, and bears the impress of his conservative and sound judgment. Those familiar with his attainments—and this must include all ophthalmologists—must regret that he has not essayed a more voluminous work. We do not agree with him that cold, to be most effective, must be *applied continuously*, since it has been shown that the contraction of the vessels which it aims to produce gives way to dilatation after three or four hours, at which time it is best to intermit the application for an hour or more. Nor do we believe he has chosen well the best method of advancement of ocular muscles. We especially recommend this book to students. That it is issued by Mr. Saunders is a sufficient guarantee of its excellence from a mechanical point of view. Especial mention should be made of the valuable bibliographic table following each chapter.

Refraction and How to Refract. Including Sections on Optics, Retinoscopy, the Fitting of Spectacles and Eye-Glasses, etc. By James Thorington, A.M., M.D., Adjunct Professor of Ophthalmology in the Philadelphia Polyclinic and College for Graduates in Medicine; Assistant Surgeon at Wills Eye Hospital; Associate Member of the American Ophthalmological Society; Fellow of the College of Physicians of Philadelphia; Member of the American Medical Association; Ophthalmologist to the Elwyn and the Vineland Training Schools for Feeble-minded Children; Resident Physician and Surgeon to the Panama Railroad Company at Colon (Aspinwall), Isthmus of Panama, 1882–1889, etc. 200 illustrations, 13 of which are colored. Philadelphia: P. Blakiston's Son & Co., 1900. Price, $1.50.

In no locality is the standard for careful refraction higher than in Philadelphia, and no man is a better exponent of careful refraction than Dr. Thorington. The book is an elaboration of his lectures on the subject at the Philadelphia Polyclinic, and begins at the beginning. The elementary facts concerning light and optics are set forth tersely and distinctly and without mathematic perplexity, and are illustrated with a number of well-made diagrams. No book advocating careful refraction can consistently do so without advocating the liberal use of mydriatics, which the author very energetically does. In this we fully agree with him. The merits of the different mydriatics (cyclo-

plegics) are carefully given, atropia being much preferred on excellent grounds. We note the preference given for "full correction," a custom which the author acknowledges to have its limitations. Thomson's chromo-aberration test is fully described, the subject being clearly illustrated with two colored plates. This method is probably no where else so satisfactorily considered. We note an absence of any reference to insufficiency of the oblique muscles, and use of "irises" instead of "irides." We are heartily in accord with the author's estimate of the value of the ophthalmometer, as *suggestive only;* and his advice, never to prescribe on its findings alone, will certainly meet with the approval of all who are familiar with the instrument, excepting only a few enthusiasts who ought to know better and probably do. Retinoscopy, as was to be expected, is regarded with the high favor which it deserves, and the author's opinion on this is that of one who speaks authoritatively. The book is one which should be in the hands of every ophthalmologist. The beginner will be by it started in paths from which his experience will never oblige him to deviate, and the older hand will find in it much of value and interest. It is the most admirable guide to careful and conscientious refraction with which we are familiar, and reflects credit on its author, as well as on the "static refraction" of Philadelphia. We would especially commend it to those afflicted with "Manhattan myopia." The publisher has furnished excellent presswork and illustrations.

BOOKS AND PAMPHLETS RECEIVED.

Operative Surgery. By Joseph D. Bryant, M.D., Professor of the Principles and Practice of Surgery, Operative and Clinical Surgery, University and Bellevue Hospital Medical College; Visiting Surgeon to Bellevue and St. Vincent's Hospitals; Consulting Surgeon to the Hospital for Ruptured and Crippled, Woman's Hospital, and Manhattan State Hospital for the Insane; Fellow of the American Surgical Association; former President of the New York Academy of Medicine; President of the New York State Medical Association, etc. Volume I. General Principles, Anesthetics, Antiseptics, Control of Hemorrhage, Treatment of Operation Wounds, Ligation of Arteries, Operations of Veins, Capillaries, Nervous System, Tendons, Ligaments, Fasciæ, Muscles, Bursæ and Bones, Amputations, Deformities, Plastic Surgery. This volume contains seven hundred and forty-nine illustrations, fifty of which are colored. New York. D. Appleton & Co. 1899.

A Manual of the Diagnosis and Treatment of the Diseases of the Eye. By Edward Jackson, A.M., M.D., Emeritus Professor of Diseases of the Eye in the Philadelphia Polyclinic; formerly Chairman of Section on Ophthalmology of the American Medical Association;

Member of the American Ophthalmological Society; Fellow and Ex-President of the American Academy of Medicine. With one hundred and seventy-eight illustrations and two colored plates. Philadelphia. W. B. Saunders. 1900.

Refraction, and How to Refract, including Sections on Optics, Retinoscopy, the Fitting of Spectacles and Eye-Glasses, etc. By Jas. Thorington, A.M., M.D., Adjunct Professor of Ophthalmology in the Philadelphia Polyclinic and College for Graduates in Medicine; Assistant Surgeon at Wills' Eye Hospital; Associate Member of the American Ophthalmological Society; Fellow of the College of Physicians of Philadelphia; Member of the American Medical Association; Ophthalmologist to the Elwyn and the Vineland Training Schools for Feeble-minded Children; Resident Physician and Surgeon to the Panama Railroad Co., at Colon (Aspinwall), Isthmus of Panama, 1882–1889, etc. Two hundred illustrations, thirteen of which are colored. Philadelphia. P. Blakiston's Son & Co. 1900.

Saunders' Question-Compends, No. 11. Essentials of Diseases of the Skin, including the Syphilodermata. Arranged in the form of Questions and Answers. Prepared especially for students of medicine. By Henry W. Stelwagon, M.D., PH.D., Clinical Professor of Dermatology in the Jefferson Medical College; Physician to the Department for Skin Diseases, Howard Hospital; Dermatologist to the Philadelphia Hospital, etc. Fourth edition, thoroughly revised. Illustrated. Philadelphia. W. B. Saunders. 1899.

A Textbook of the Practice of Medicine. By Jas. M. Anders, M.D., PH.D., LL.D., Professor of the Practice of Medicine and of Clinical Medicine in the Medico-Chirurgical College, Philadelphia; Attending Physician to the Medico-Chirurgical and Samaritan Hospitals, Philadelphia, etc. Illustrated. Third edition, revised. Philadelphia. W. B. Saunders. 1899.

A Practical Treatise on Materia Medica and Therapeutics. By Roberts Bartholow, M.A., M.D., LL.D. Professor Emeritus of Materia Medica, General Therapeutics and Hygiene, in the Jefferson Medical College of Philadelphia; formerly Professor of Materia Medica and Therapeutics and of the Practice of Medicine in the Medical College of Ohio; Fellow of the College of Physicians of Philadelphia; Member of American Philosophical Society; Honorary Fellow of Royal Medical Society of Edinburgh; Honorary Mem-

ber of Societe Medico-pratique de Paris, and of various National, State, and County Medical Societies. Author of a Treatise on the Practice of Medicine; of a Treatise on Medical Electricity; of a Manual of Hypodermatic Medication; of the Russell and Jewett Prize Essays, and Prize Essays of the American Medical Association and of Rhode Island Medical Society, etc. Tenth edition, revised and enlarged. New York. D. Appleton & Co. 1899.

Saunders' Question-Compends, No. 4. Essentials of Medical Chemistry, Organic and Inorganic. Containing also Questions of Medical Physics, Chemical Philosophy, Analytical Processes, Toxicology, etc. Prepared especially for students of medicine. By Lawrence Wolff, M.D., Demonstrator of Chemistry, Jefferson Medical College; Physician to the German Hospital, of Philadelphia; Member of the German Chemical Society, of the Philadelphia College of Pharmacy, etc. Fifth edition, thoroughly revised by Smith Ely Jelliffe, M.D., PH.D., Professor Pharmacognosy, College of Pharmacy of the City of New York; Clinical Assistant, department of Neurology, Columbia University, New York. Philadelphia. W. B. Saunders. 1899.

NEWS AND NOTES.

DR. F. S. RAYMOND has been re-elected County Health Officer, a merited reward for good service.

DR. G. G. BUFORD, of this city, is arranging for an excursion to the Paris Exposition for physicians, their families and friends.

DR. JOHN I. TAYLOR, an eye and ear surgeon, formerly of this city, but later of Jackson, Tenn., committed suicide on January 17 at Jackson.

MR. GEO. HESSEN, apothecary to the City Hospital, has been removed, and Mr. West appointed in his place. The charges against Mr. Hessen have not been made public.

$100,000 TO STUDY CANCER.—By the will of Caroline Brewer Croft, who died in England nearly two years ago, a sum amounting to nearly $100,000 has been placed in the hands of the corporation of Harvard University, to be used in the investigation of cancer.

The January number of the Lancet contained a clipping from the *New Orleans Medical and Surgical Journal* on Glycosuria, without crediting the source. This is our first, and we hope, the only lapse, and occurred from it having been pigeonholed at the time and not re-read before it went to the printer.

The proof of the book review of Barker on the Nervous System in the December Lancet, failed to reach the writer before it went to press, and, as a result, several errors crept in. "Lewellyn" appears instead of "Lewellys," and Ramon's name is chopped in two; it was meant to read Santiago Ramon (y Cayal).

The International Medical Annual for 1900, E. B. Treat & Co., will soon appear. We take pleasure in making this announcement, since the Annual gives in a rather small volume, a very complete summary of the year's progress. The small price asked for the book is calculated to place it within every one's reach. A full review of the book will appear later.

The following standing committees have been appointed for the Memphis Medical Society for 1900:

Committee on Credentials—Dr. Heber Jones, Chairman.
Dr. E. M. Holder.
Dr. Alfred Moore.

Censors—Dr. E. E. Haynes, Chairman.
Dr. M. Goltman.
Dr. G. G. Buford.

At the meeting of the Southern Surgical and Gynecological Association in New Orleans, December 5–7, 1899, the following officers were elected:

President—Dr. A. M. Cartledge, of Louisville.
Vice-Presidents—Dr. Manning Saunders, of Charleston.
Dr. W. P. Nicholson, of Atlanta.
Secretary—Dr. W. E. B. Davis, of Birmingham.
Treasurer—Dr. W. D. Haggard, Jr., of Nashville.

The next meeting will be held in Atlanta, Ga., in November, 1900.

In the case of Eichberg vs. Sale, a verdict of $1500 was rendered for the plaintiff. The suit was against Dr. E. P. Sale, of this city, for a bad result from a fractured humerus. Be it said to the credit of the Memphis physicians that none of them could be brought to

testify adversely to the defendant. The prosecution rested on flimsy evidence, mainly the patient's own statement, and the verdict is generally regarded as unjust. The LANCET hopes that the appeal, which will be taken, will justify Dr. Sale's management of the case.

COMPETITION FOR THE AMERICAN MEDICAL ASSOCIATION MEDAL.—At the meeting of the American Medical Association, held June 4, 1897, it was resolved to restore the former policy of the Association in favor of offering annually a gold medal for meritorious scientific work. The committee for this year, consisting of Drs. George M. Gould of Philadelphia, E. Fletcher Ingals of Chicago, and T. W. Huntington of Sacramento, Cal., desires to direct attention to the following rules governing the competition:

The commercial value of the medal shall be $100.

A standing committee on prize medals, consisting of three members of the Association, shall be elected by the Business Committee.

The competing essays shall be typewritten or printed and shall bear no mark revealing their authorship; but instead of the name of the author, there shall appear on each essay a motto, and accompanying each essay shall be a sealed envelope containing the name of the author and bearing on its outer surface the motto of identification. No envelope is to be opened by the committee until a decision has been reached as to the most deserving essay, and the other essays have been returned to their respective owners. The committee shall have authority to reject and return all essays in case none have been found worthy of the Association medal. Competing essays must be in the hands of the committee not later than March 1, 1900.

TO THE MEMBERS OF THE MEDICAL PROFESSION IN THE UNITED STATES.—The cause of humanity and of scientific progress is seriously menaced. Senator Gallinger has again introduced into Congress the Bill for the "Further Prevention of Cruelty to Animals in the District of Columbia," which he has so strenuously and misguidedly advocated in the last two Congresses. It is Senate Bill No. 34. Twice the Committee on the District of Columbia has, also unfortunately and misguidedly, reported the bill with favorable consideration. It is speciously drawn to seem as if it were intended only in the interest of prevention of cruelty to animals, but the real object is twofold: 1, to prohibit vivisection and, 2, to aid the passage of similar bills in all the State legislatures.

It hardly needs to be pointed out that this would interfere with or even absolutely stop the experimental work of the Bureau of Animal Industry and the three Medical departments of the Goverment, the Army, the Navy, and the Marine-Hospital Service. The animals themselves might well cry out to be saved from their friends. No more humane work can be done than to discover the means of the prevention of diseases which have ravaged our flocks and herds. All those who raise or own animals, such as horses, cattle, sheep, pigs, chickens, etc., are vitally interested in the preservation of their health and the prevention of disease.

The inestimable value of these scientific researches as to the prevention and care of disease among human beings it is superfluous to point out. Modern surgery and the antitoxin treatment of diphtheria alone would justify all the vivisection ever done.

As my attention has been called officially to the introduction of the bill, I take the opportunity of appealing to the entire profession of the country to exert itself to the utmost to defeat this most cruel and inhuman effort to promote human and animal misery and death and to restrict scientific research. It is of the utmost importance that *every physician* who shall read this appeal shall *immediately* communicate especially with the Senators from his State, shall also invoke the aid of the representitives from his or other districts in his State, and by vigorous personal efforts shall aid in defeating the bill.

It is especially requested also that all of the national, State and county societies, at their next meeting, take action looking toward the same end. If regular meetings are not soon to be held, special meetings should be called. Correspondence is invited from all those who can give any aid.

The Committee on the District of Columbia consists of Senator Jas. McMillan, Michigan, Chairman, and Senators J. H. Gallinger, New Hampshire; H. C. Hansborough, North Dakota; R. Redfield Proctor, Vermont; J. C. Prichard, North Carolina; Lucien Baker, Kansas; C. P. Wetmore, Rhode Island; C. J. Faulkner, West Virginia; Thos. F. Martin, Virginia; Wm. M. Stewart, Nevada; and Richard Kenney, Delaware. Personal letters may be addressed to them or to other Senators. Petitions should be addressed to the Senate of the United States.

W. W. KEENE, M.D.
President American Medical Association.

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CLINICAL NOTES.

THE steamships *City of Rome* and *State of Nebraska* have been chartered to leave New York on June 30, 1900, especially for physicians, their families and friends who desire to visit the Paris Exposition and other parts of Europe. Trip to last thirty-two days. Rates low and first-class passage. The physicians of the West are going in a body, and the physicians of Alabama, Mississippi, Louisiana, Arkansas, Tennessee and Indian Territory have been invited to go with them.

For full particulars, address G. G. BUFORD, M.D., Memphis, Tenn.

THERAPEUTIC USES OF GUDE'S PEPTO-MANGAN.—A. Fasano, professor of the University of Naples, Italy, has published a very elaborate article on the newer preparations of iron and manganese, and after a very minute study from a chemical, physiologic and therapeutic point of view, comes to the conclusion that the only one of real merit is Gude's Pepto-Mangan, in the treatment of anemia and chlorosis, no matter from what cause. He shows conclusively how both the iron and the manganese are necessary in the treatment of these affections, and also how Gude's Pepto-Mangan meets all the requirements of an iron and manganese medication without any of their disadvantages. He reports over one hundred cases successfully treated by it.

PETROLEUM IN MEDICINE.—We are in receipt of the Jan., 1900, number of *The Petroleum Idea*, a journal published to emphasize the use of petroleum in medicine. It contains several articles on the therapy of petroleum as being of special value in winter coughs, bronchitis, tuberculosis, and lagrippe. The Petroleum Emulsion, one of the preparations advocated, is manufactured by The Angier Chemical Co., of Boston, Mass.

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is the only perfect digestive. It digests every variety of food. In physiological activity it presents the active and mother ferments of the entire group of digestive organs. It aids digestion by furnishing an additional supply of protoplasmic material out of which active ferments are elaborated, and perfects the process by increasing cellular activity.

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At this season of the year, when physicians are called upon to treat many rheumatic and neuralgic conditions, the successful practitioner naturally desires a reliable remedial agent. There is nothing which will correct rheumatism, neuralgia, grippe, nervous headache, gout, sciatica and lumbago more promptly and thoroughly than the Tongaline preparations. Tongaline is the logical prescription for these complaints as it contains the anodyne action of tonga, the antiseptic and anti-rheumatic action of salicylic acid, the anti-spasmodic action of cimicifuga, the cathartic and diuretic action of colchicine, and diaphoretic action of pilocarpine. Hence it will be observed that Tongaline is constructed for the purpose of inducing general elimination, which it accomplishes by its stimulating action on the liver, bowels, kidneys and pores, whereby the poisonous and viscid secretions which are the cause of the diseases mentioned above are speedily removed. Attention is called to the very important fact that all of the salicylic acid used in Tongaline is made from the purest natural oil of wintergreen, and according to the most eminent medical authorities this salicylic acid is the only kind which should be taken into the system, as the use of the synthetic product is apt to be attended by very injurious consequences.

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WE APPRECIATE THE CONFIDENCE placed in us by the medical profession and public, and we assure both that we guard it zealously. Our every effort is to deserve more and more the continued good faith and patronage of both. Our past success is due entirely to our painstaking and careful service, combined with the use of the BEST goods obtainable. On this basis we shall continue to do business.

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Crutches, Trusses, Surgical Dressings, and requisites for the sick.

Gonorrhea and Vulvo-Vaginitis in Children.—Dr. Nosotti (*British Med. Journal*, Sept. 30, 1899) speaks well of protargol in the treatment of gonorrhea at all stages. The solutions used varied from ½ per cent. in the early days to 2 per cent. in the later stages. No ill-effects were noticed, no epididymitis or other secondary inflammation. It was more satisfactory as an injection than permanganate of potash. It was found very useful in the vulvo-vaginitis of children. Protargol causes a free elimination of epithelial and pus cells of gonococci from the urethral mucous membrane.

Dr. J. H. Mulhall, of St. Louis, a well-known laryngologist, suicided on January 11. The act was prompted by the sufferings of an incurable nervous affection.

The Dios Chemical Co., of St. Louis, Mo., manufacturers of the standard remedies: Dioviburnia, uterine tonic; Neurosine, neurotic; Sennine, antiseptic dry dressing; Palpebrine, external eye diseases, will mail to physicians free of charge their new combination paper weight and mirror on receipt of 10 cents to pay postage.

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To the Medical Profession:

The Board of Health makes the following examinations free for the city Physicians: Exudate and sputum for diphtheria and tubercle bacilli, typhoid and yellow fever blood reaction and malaria organisms, well and cistern water and milk.

For other work I will charge the following fees: Urinalysis, chemical and microscopical, $2.00; including staining for tubercle bacilli, $3.50. Quantitative for sugar, $2.50. This covers the work necessary to make a conscientious diagnosis, and for *life insurance*. Pus for gonococci and other microörganisms, $2.00. Feces for parasites, eggs, etc., $5.00. Blood for typhoid and yellow fever reaction, for malaria organisms, diphtheria exudate and sputum for tubercle bacilli, $2.00. Other examinations for poisons, etc., according to labor and material consumed.

FELIX PAQUIN, Ph. B.,

Chemist and Bacteriologist of the Board of Health.
Member of the Association of Official Agricultural Chemists.

The New Local Anesthetic, "Nirvanin."—August Luxemburger (*Phila. Monthly Med. Journal*, July, 1899) states:

In number 49, 1898, of the *Munchener medicinische Wochenschrift*, Prof. Einhorn and Dr. Heinz, in a paper entitled "The Continuation of the Researches with Orthoform," call attention to a new anesthetic discovered by them, the hydrochlorate of diethyl-glycocoll-p-amid-o-oxybenzoic-methylester, which they call Nirvanin, and whose various merits seem to warrant a lasting and prominent place among the hitherto recognized anesthetics.

A one-tenth per cent. solution of Nirvanin administered after the well-known infiltration method of Schleich produced an analgesic swelling, the analgesia lasting about five minutes. He gives the average duration as increasing with the percentage of the solution—thus, one-fifth per cent. twelve minutes, one per cent. twenty minutes, two per cent. twenty-three minutes. It was found that the analgesia from one-fifth per cent. outlasted the swelling by several minutes, therefore dismissing the thought of paralysis of the sensory nerve fibers by solitary edema as a cause for the anesthesia. He was able to remove small growths by the aid of a one-fifth solution without pain. After a long series of experiments he arrives at the following conclusions:

1. Nirvanin, in the concentration used in his experiments, is non-poisonous.

2. It is preferable to cocain for the production of infiltration and regional anesthesia.

The *American Gynecologist and Obstetrical Journal* of July, 1899, in its Therapeutic Forum, reports a series of cases treated with Gray's Glycerine Tonic Compound, and draws the following conclusions:

1. The remedy in question is an efficient stomachic; it engenders appetite, facilitates digestion, promotes assimilation of food, and overcomes atonic conditions of the mucous membrane and muscular coat of the stomach.

2. Because of its powers of increasing assimilation of food, it is a valuable adjunct to the treatment of general debility, anemia, and nervous exhaustion.

3. It checks fermentation in the stomach and stimulates inactive gastric functions; hence its value in selected cases of chronic gastric catarrh, associated with fermentation and deficient motor and secretory powers of the stomach.

DYSMENORRHEA

DIOVIBURNIA is **the reliable remedy** in dysmenorrhea (invaluable in congestion), relieving pain and regulating the uterine functions, possesses **antispasmodic** properties which are exerted especially on the uterus and appendages. **Unexcelled** in leucorrhea, amenorrhea, menorrhea, menorrhagia. Vomiting in pregnancy, threatened abortion, miscarriage, **parturition** and **subinvolution.** In female neurosis combine **Neurosine** (Dios) two parts to **Dioviburnia** four parts.

Should there be any physician who has not received samples, we will furnish full size bottles free, they paying express charges.

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A Favorite Remedy in the Treatment of

Pulmonary Phthisis, Bronchitis, Scrofulous Taint, General Debility, Etc.

Formula: Stimulates Digestion and Promotes Assimilation.

Each fluidounce contains:

Hypophosphite	Soda	2 grains.
"	Lime	1½ "
"	Iron	1½ "
"	Quinine	¾ "
"	Manganese	1½ "
"	Strychnine.	1-16 "

Dose: One to four fluidrachms. **PINT BOTTLES, $1.00**

This preparation does not precipitate, retains all the salts in perfect solution.

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Hypophosphites with Wild Cherry Bark, a very Valuable Combination.
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And Where Nature fails to make Good Blood,
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BOVININE is Bovine Blood Unaltered from the Arteries of the Bullock;
The Universal Auxiliary of Modern Medicine and Surgery,
and the TRUE "ANTITOXIN" of Healthy Nature.

In the more enlightened progress of Modern Medicine, "Blood-letting" has given place to Blood-*getting*.

Aye! Get Good Blood—but How? Not by the Alimentary Process. It has already failed to do its work (else the patient would not be sick); and in acute disease must not even be allowed to do the work it can. Stimulate as you will, the whole sum of the patient's alimentary power when fully forced into play, is unable to keep up the nourishing and supporting contents of the blood. There is absolutely but one thing to do; and, thank God, that can be done, usually with success, as ten-thousand-fold experience has proved. That one thing is this: where Nature fails to PRODUCE good and sufficient Blood, WE CAN INTRODUCE IT from the arteries of the sturdy bullock, by the medium of BOVININE.

The vital activity of this living blood conserve rests on no man's assertion: it speaks for itself, to every properly equipped physician who will test its properties microscopically, physically, or therapeutically.

TRY IT IN PRACTICE.

TRY it in ***Anæmia,*** measuring the increase of red cells and hæmaglobin in the blood as you proceed, together with the improving strength and functions of your patient.

Try it in ***Consumption,*** with the same tests from week to week.

Try it in ***Dyspepsia*** or Malnutrition of young or old, and watch the recuperation of the paralysed alimentary powers.

Try it in ***Intestinal*** or gastric irritation, inflammation, or ulceration, that inhibits food itself, and witness the nourishing, supporting and healing work done entirely by absorption, without the slightest functional labor or irritation; even in the most delicate and critical conditions, such as Typhoid Fever and other dangerous gastro-intestinal diseases, Cholera Infantum, Marasmus, Diarrhœa, Dysentery, etc.

Try it per rectum, when the stomach is entirely unavailable or inadequate.

Try it by ***subcutaneous*** injection, when collapse calls for instantaneous blood supply—so much better than blood-*dilution!*

Try it on ***Chronic Ulceration,*** in connection with your antiseptic and stimulating treatment (which affords no nourishment) and prove the certainty and power of topical blood nutrition, abolishing pus, stench, and PAIN, and healing with magical rapidity and *finality.*

Try it in ***Chronic Catarrhal*** Diseases; spraying it on the diseased surfaces, with immediate addition of peroxide of hydrogen; wash off instantly the decomposed exudation, scabs and dead tissue with antiseptic solution (Thiersch's); and then see how the mucous membrane stripped open and clean, will absorb nutrition, vitality and health from intermediate applications of pure bovinine.

Try it on the ***Diphtheritic Membrane*** itself, by the same process; so keeping the parts clean and unobstructed, washing away the poison, and meanwhile sustaining the strength independently of the impaired alimentary process and of exhaustive stimulants.

Try it on ***anything,*** except plethora or unreduced inflammation; but first take time to regulate the secretions and functions.

Try it on the ***patient*** tentatively at first, to see how much and how often, and in what medium, it will prove most acceptable—in water, milk, coffee, wine, grape, lemon or lime juice, broth, etc. A few cases may even have to begin by drops in crushed ice.

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THE

MEMPHIS LANCET.

VOLUME IV. MARCH, 1900. No. 3

ORIGINAL ARTICLES.

FRACTURES OF THE LOWER EXTREMITIES.*

BY JERE LAWRENCE CROOK, A.M., M.D.
JACKSON, TENN.
District Surgeon I. C. R. R., Jackson, Tenn.

It is a generally accepted fact that in societies such as this the most benefit is to be derived from papers relating to the author's own experience, rather than from those containing lengthy excerpts from textbooks. The title of this paper is a practical one, and I shall endeavor to make the contents correspond by reporting some cases of my own and conclusions therefrom.

Fractures of the lower extremity may naturally be considered under three heads—those of the hip, thigh and leg. I will report four cases of

Fractures of the Neck of the Femur.

Case I. J. C., aged 23, single, Jackson, Tenn. While engaged in repairing lines of the electric light company, he touched a live wire, which gave him a terrific shock, burning his hands and causing him to fall a distance of fifteen feet to the ground. The diagnosis made under chloroform was fracture of the femoral neck, and Buck's extension with eighteen pounds weight was applied, reinforced with sandbags to assist in holding limb in position.

The weight was gradually lessened after the fourth week and dressings removed at end of ninth week. There was ligamentous union only, patient being unable to bear any weight on limb. He was again put to bed with sandbags and no weight and kept

* Read before the West Tennessee Medical Society, at Milan, Dec. 14, 1899.

there four weeks longer, when he was allowed to move about with crutches. One year after his injury union had so far progressed that he could walk very well with a cane and limped only slightly without one. There was no shortening.

Case II. Mrs. W. D., aged 55, married, Jackson, Tenn. Walked to the window to throw away some pea hulls and wrenched her body in such a way as to throw her to the floor. She did not consider herself seriously hurt, though she could not walk, and had to be carried to the bed. I did not see her until second day after the injury, when upon examination I found shortening and eversion of the limb. Following my usual custom chloroform was administered, when the fracture was readily diagnosed and the limb set as in Case I, using an iron bed and a hard mattress. The limb healed slowly but firmly, with half-inch shortening, and she walked in about eight months, with a cane.

Case III. Mrs. J. H. S., aged 68, married, Whiteville, Tenn. While on a visit to Jackson, sustained a fractured hip in getting off street car, being thrown to the ground by a sudden start of the car. This fracture was not diagnosed at first visit, nor until the third day, there being no shortening or eversion of the limb. On account of her age, persistent pain about joint and history of a fall, I decided to anesthetize patient and make the diagnosis certain. Having provided an iron bed, hard mattress and weight and pulley apparatus, patient was chloroformed and an impacted fracture was readily found. The extension apparatus was applied in the usual way, and patient made an uneventful recovery, with firm union and no deformity.

Case IV. Mrs. C., aged 60, married, Jackson, Tenn. While crossing street, stepped down off sidewalk suddenly and fell to the ground. She was lifted and carried into her house, and I visited her at once. Great pain about hip joint, shortening and eversion were the symptoms present. She was made as comfortable as possible, that night, and the next morning under anesthesia, the limb was treated, as in the other cases. Result good, firm union and no shortening.

Fractures of the Shaft of the Femur.

Case I. James N., aged 28, single, Jackson, Tenn. In a collision on the I. C. R. R., he jumped from engine cab to save his life and struck a pile of crossties, sustaining a double fracture of right femur at lower and middle thirds, compound fracture of tibia and fibula, and compound fracture of radius and ulna at wrist. The fractures were accurately determined and reduced and temporarily dressed under anesthesia and he was brought from Russell, Tenn., to Jackson, and removed to his home. Buck's extension was applied to the right leg and temporary dressings reapplied to the other fractures. In the course of a week a plaster-of-paris dressing was applied over the adhesive plaster dressing. This procedure I had never seen suggested in connection with extension by weight and pulley, but the exigency of this case demanded both plaster and extension as the femur was completely fractured in two places, six inches apart. At the end of five weeks the plaster-of-paris was renewed on account of the shrinkage in size of the limb and consequent loosening of the cast. At the end of ten weeks all dressings were removed, and perfect union with no deformity nor shortening had occurred.

Case II. J. C., aged 4, Jackson, Tenn. While playing about the house with his brother was thrown down with such force as to fracture his thigh. He was anesthetized, when the fracture was readily made out and a plaster-of-paris cast was applied from ankle to groin, and patient placed on a firm mattress. Cast was removed in six weeks, when the result was all that could be desired—firm union and no shortening.

Case III. W. D., aged 6, Jackson, Tenn. While playing about his mother's tombstone in the cemetery, a portion of the stone was dislodged, falling on the little fellow's thigh. He was brought home and I was hurriedly summoned. The fracture was readily diagnosed at upper third, but in order to properly reduce the fracture the patient was anesthetized, the dressings being in readiness, and another fracture was found near the knee joint. Buck's extension was applied reinforced by a plaster-of-paris cast, as in Case I. The case progressed well, though it was very difficult to keep the patient in position. At the end of the eighth week firm union was found to be established, and I was much gratified a few weeks after to see my little patient as sound as ever, with no evidence of his injury apparent in his gait.

Fractures Below the Knee.

Case I. H. L. B., aged 30, single, Jackson, Tenn. Stepped from the doorway of his store to the pavement, wrenching his foot in such a way as to fracture the fibula near ankle joint, rupturing the external lateral ligament. Temporary dressings of binder's board molded for the back of the leg and lateral splints of the same material were applied, followed in the course of ten days by a plaster-of-paris cast. Results: healing was slow, patient limped for several weeks after removal of cast. Final result perfect.

Case II. J. B., engineer I. C. R. R., Jackson, Tenn. Jumped from train while in motion at Fulton, Ky. Diagnosis of sprained ankle made by local surgeon. I saw him four days later in Jackson, when the limb was found to be much swollen and the patient suffering greatly. Careful examination elicited crepitation and preternatural mobility on the fibular side and the diagnosis of Potts' fracture was made. This being a case where there was a difference of opinion, it was necessary, in order to convince the patient that his leg was broken, for me to make firm pressure at the site of fracture. The patient then emitted a howl of pain, and admitted my diagnosis. The limb was encased in hot lead and laudanum lotion, placed in binder's board splints, followed in course of two weeks by a plaster cast. Result perfect.

Case III. J. L., aged 26, single, near Jackson, Tenn. Sustained a Potts' fracture by getting foot caught in gin machinery. Dressing; temporary splints of binder's board followed by plaster cast in two weeks, as in Case I. Result entirely satisfactory.

Case IV. W. W., aged 8, Jackson, Tenn. While attempting to jump on rear of delivery wagon was thrown to the ground, sustaining a Potts' fracture. Case treated as I, II and III. Result perfect, in much shorter time than either of the others, on account of youth of the patient.

Case V. Compound fracture tibia and fibula. This was the left leg of the first patient reported in cases of Fractures of Thigh. Rigid asepsis and antisepsis were practiced here, and to that in a large measure must certainly be attributed the good result. The limb was shaved, thoroughly washed with bichloride of mercury solution, 1-1000 strength, and the wound irrigated with the same solution. It was dressed as often as circumstances demanded, and plaster cast was not applied until the skin wound was healed, which was at end of fourth week. He was kept on specific treatment during entire period of his disability. All of his six fractures healed perfectly and in eight months after his injury he was able to resume his position as conductor on the I. C. R R., where he is today.

Case VI. C. P., aged 22, single, Jackson, Tenn. While attempting to board a switch engine of N. C. & St. L. Ry., fell and struck leg on step, producing compound fracture of both tibia and fibula. In this case also, as in Case V, the most rigid asepsis and antisepsis were practiced and the skin wound made to heal before applying the plaster cast. Result perfect.

Case VII. Mrs. C., aged 58, on November 5, 1899, while walking about the room in her home, stepped on the hearth, which was lower than the floor, and wrenched her foot in such a way as to fracture the fibula and rupture the external lateral ligament. She is a very large woman, weighing about two hundred pounds, and when her foot careened to the outside she still endeavored to maintain her equilibrium. This threw her entire weight on the tibia, resulting in a comminuted fracture into the ankle joint. I have never seen a case where so severe an injury was produced by so slight a cause. The limb was dressed with a posterior metallic splint, and lateral splints of binder's board very thickly padded with absorbent cotton. The swelling and tension were so great that the dressings were removed a few hours later, the leg bathed in hot water, and dressings reapplied with hot lead and laudanum lotion on absorbent cotton next to the limb. It was dressed for three days in like manner, but on the fourth day blisters appeared over the site of the fracture on both sides, and the skin assumed a dark, threatening aspect. The blisters were opened and the entire leg bathed in hot bichloride lotion and compresses wrung out of the same solution applied, with bichloride gauze next to the skin. This dressing was repeated every day for a week before we were sure we could save the limb, the patient meanwhile having been placed on strong tonics, as an additional precaution against gangrene. On December 8th, a small ulcer which had formed over internal malleolus was curetted and probed and a small piece of dead bone removed. The wound was freely irrigated with bichloride solution and packed with gauze. December 12, the wound was again examined and found to be granulating nicely, with no evidence of further necrosis. There is at this time, six weeks after injury, firm union, and fair motion in ankle joint, which, under the circumstances is very gratifying.

Conclusions.

I. As to fractures of the femoral neck.

1. Any injury about the hip, however slight the cause, in a person past 45, should receive the most careful attention.

2. Impacted fractures do not present marked symptoms, and are therefore more apt to be unrecognized.

3. It is never safe to give a positive opinion in these cases without anesthetizing patient or making an X-ray examination. The latter, however, is not often convenient, while the former is always available.

4. It is not necessary to differentiate between intra- and extra-capsular fractures, as the treatment in both cases is identical.

5. The simple Buck's extension apparatus with patient on a firm mattress and iron bed (weight varying to suit the case) gives as good results as can be obtained.

II. As to fractures of the femoral shaft.

1. It is a wise plan here also to use anesthesia in making the reduction, as it is painless to the patient and absolutely satisfactory to the surgeon.

2. I wish to call special attention to the use of the combined extension and plaster apparatus, especially in double fracture, where the difficulty of securing permanent apposition and absolute rest is so great. This combination I have never seen suggested by any other person.

III. As to compound fractures.

1. Success or failure in these cases depends almost entirely upon the first dressing, hence the absolute necessity of rigid antiseptic measures.

2. If we are not able to sterilize the wound otherwise, it is far better to cut down on the fracture, irrigate and treat it as an open wound, than to take any risk of infection.

Finally.

There are no classes of injury where surgery is brought so much into disrepute and where surgeons suffer more criticism and malpractice suits than in fractures. Consequently, with the combined experience of our predecessors and contemporaries to warn and guide us, it behooves us to use every means at our command to make accurate diagnoses and accomplish successful results. The X-ray is a wonderful and useful adjunct in all fractures and should be used when available, wherever the least doubt of the diagnosis exists. The motto of old Davy Crockett, "Be sure you are right, then go ahead," finds here a most fitting application.

Apomorphin in Delirium Tremens.—R. F. Lewis (*N. Y. Medical Journal*, January 27, 1900) used apomorphin to evacuate the stomach of a patient who had been on a protracted and violent spree. He was surprised to note that the intense excitement, the asthmatic difficult respiration, and all the other symptoms of alcoholic delirium, soon subsided, and the patient was easily controlled.

SMALLPOX.*

BY F. S. RAYMOND, M.D.
MEMPHIS, TENN.
County Physician to Shelby County; Physician to the City Hospital.

Smallpox is one of the oldest diseases of which we have any history. As to the exact date of its first appearance there is no definite knowledge, but we have no doubt of its existence five hundred years before the Christian era. Smallpox is no respecter of persons. Crowned heads have fallen victims to its ravages; among them may be mentioned Henry, Duke of Gloucester, Mary, Princess of Orange and mother of William III, Mary, Queen of England and wife of William III, Joseph, Emperor of Germany, Peter II, Emperor of Russia, Henry, Prince of Prussia, and others. Macaulay, an English historian, refers to the disease as "the most terrible of all the ministers of death." Prior to the introduction of inoculation of cowpox by Jenner in 1796, smallpox was indeed a dreadful disease. In England nine per cent. of all deaths was due to it. During the sixteenth century in Mexico three million five hundred thousand people died of smallpox. About this time whole tribes of North American Indians were exterminated by it. The annual mortality in England is said to have been three thousand to each million inhabitants. In France thirty thousand died of it each year, and in Russia two million died in one year. From 1783 to 1799, inclusive, one-tenth of the entire death rate of Berlin was caused by smallpox.

Now when we compare the foregoing statements with the smallpox as it has appeared in nearly every State in the Union, Mexico and Canada, in 1899, we do not so much wonder that there exists a difference of opinion as to whether the smallpox of this year is really variola vera. It is to this feature of the subject that I shall more especially ask your indulgence.

From an experience of five years of almost constant handling of the disease, and from all the facts I have been able to collate, I am very much of the opinion that Dr. Happel's "Pseudo Smallpox

* This paper is a reply to one on "Pseudo Smallpox in Gibson County," read by Dr. Happel at the Tri-State Medical Association in November.

in Gibson County," and other similar instances of a rather new and mysterious disease occurring usually among the negroes and spreading from town to hamlet, from hamlet to farm, and from one farm to another, were variola vera, though of a mild form.

In the public health reports published by the United States Marine-Hospital Service for last year, I find that the disease has appeared in thirty-one States in this country, and in various places in Mexico and Canada; and in almost, if not in every, instance the disease prevailed throughout in the mildest form ever known by those who had to do with it. Indeed, so generally was this the case, that not only in Tennessee, but in many other places, has difference of opinion among medical men connected with boards of health caused great delay in inaugurating measures to stamp out the disease; and great expense has been incurred as the result of refusals of boards of health, or others in charge of the situations, to believe there was danger, or to accept the diagnosis of smallpox. Two instances of this nature may here be mentioned:

Smallpox appeared at Danville, Pittsylvania county, Va., on May 31, 1899, but was not recognized as variola at all on account of its very mild form, and the secretary of the State board of health was ordered there, but failed to convince the local authorities that the disease was smallpox, and a surgeon of the Marine Service was sent there before the diagnosis was made, when it was then positively declared to be smallpox.

Dr. C. P. Wertenbaker, passed assistant surgeon of the Marine-Hospital Service, reported smallpox in Warwick county, Va., in April, 1899, but the local board of health positively refused to take any steps toward getting rid of it or restricting its spread. The Governor of Virginia requested the secretary of the State board of health to meet Dr. Wertenbaker there, and after all other means devised by them had failed, the former told the local boards, municipal and medical, that if they did not get to work isolating and vaccinating, the county, including Newport News, would be declared infected and quarantined. Then, and not till then, was anything done, and not until after eight hundred and ninety-one cases of smallpox had developed.

While West Tennessee is not the only place where there exists a difference of opinion in the minds of those connected with departments of public health, yet to those of us in this section, and espe-

cially in Shelby county and the city of Memphis, the question is of the very greatest importance, inasmuch as these places are now being made the dumping ground for smallpox and all classes of paupers from neighboring States. Notwithstanding my appeal to the Government for the protection guaranteed us by the international quarantine law of 1893, the boards of health of Tennessee, State, county and city, are now confronted with a grave condition, and we cannot afford to temporize and quibble among ourselves as to whether some mysterious though mild disease is really smallpox, but let us make our investigations a mutual hunt for the truth rather than a controversy about nonessential points, simply because some one of us has found a disease very like smallpox, but does not come up to the standard as laid down by the older writers.

Since March, 1895, we have had in Shelby county and the city of Memphis, approximately, twelve hundred cases, treated at our emergency hospital or pesthouse. During 1895 and 1896 the disease prevailed in a very severe form, giving a death rate of nearly thirty per cent. Last year the percentage of deaths was a little more than one per cent.

I have seen the disease in all its forms, from the mildest to the hemorrhagic — purpura variolois and variola hemorrhagica pustulosa — and my experience last year convinces me beyond a doubt that the disease described by Dr. Happel is exactly what we have lately had in Shelby county. We have today, and had during the whole of last year, with the exception of two or three weeks, in our pesthouse, numbers of cases so mild that no one not familiar with the disease would for a moment regard them with any apprehension. Yet in the same ward with, and perhaps in the next bed to, those very mild cases, we have had confluent cases, and not in a single instance has one of the milder cases contracted the severer form while constantly exposed for three weeks. Furthermore, not in a single instance has one of the mild cases returned with a second attack in any form in the last five years. During the past year not but one out of each forty cases treated by us was confluent; yet I know absolutely that the one confluent case got his infection from the same source as the thirty-nine mild ones, and vice versa. So one must conclude that the extremely mild cases are variola vera, or that the confluent ones are not, which, to say the least, is absurd.

To my mind the mistake that has been made, not only in Ten-

nessee, but in various places, is that those not familiar with smallpox are looking for a much more formidable disease than need be to constitute smallpox. The distinct chill and great backache and headache preceding the severe cases are absent in the mild ones, or so nearly so as to pass unnoticed by the patient. Last year many of our patients were not aware that they were sick until arrested on the streets or at their homes. Our few confluent cases were members of the same families of those attacked with the mild form.

A common mistake, I think, is to expect secondary fever in every case. Secondary fever being essentially septic, caused by pustulation, it stands to reason that, if there is little or no pustulation, there can be but little or no fever secondarily.

From personal experience I am free to say that it is not so difficult to make a diagnosis of the disease as is the common belief. But a correct diagnosis cannot be made unless one sees and studies the disease in different stages, and not certainly by expecting to find all the symptoms, in very many cases, as are laid down in the books. I have seen good doctors treat smallpox right into the pustular stage without suspecting it to be such. To my mind such a mistake is inexcusable. No physician who *thinks* ought to fail to recognize it on the second or third day of eruption.

In making a diagnosis by elimination, I would say the diseases most likely to bewilder the doctor and to be mistaken for smallpox are measles and varicella—measles on the first day of eruption, and chickenpox at almost any stage of the eruption. However, not to mention the difference in the stages of incubation and invasion of the two diseases, if we will but remember that the temperature in measles always rises upon the appearance of the eruption, and that the opposite is true of smallpox, we will not err. Again, the eruption is macular in measles and papular in variola; the eruption is *on* the skin in measles and *in* the skin in variola, which can be determined by the fingers. The eruption in chickenpox is vesicular almost from the beginning; in smallpox it is never vesicular before the third day. However, the most distinctive difference in the eruption of the two diseases, and one which we may safely rely on, is that in chickenpox the vesicles appear in successive crops; that is to say, if we observe a fresh vesicle today, tomorrow it will be bursted and dried, and within an inch of it we will find that another has just appeared. This never occurs in smallpox in any

form, mild or otherwise. The papules, vesicles and pustules appear and mature in almost the same length of time.

The papular form of secondary syphilis might puzzle a physician not accustomed to smallpox, but if the history of the case is looked into, it is scarcely possible to make a mistake.

In any given case of suspicious eruption, especially in the negro race — and I say especially in this race because no eruptive disease is as easily diagnosed in the black man as in the white—one of the first steps to be taken in an investigation should be to examine the arms of the suspect for vaccination marks, and if a tolerably recent and well-defined cicatrix is found, we may almost positively exclude smallpox. But we of course know that vaccination, though perfectly done with positive effect, does not always prevent smallpox; neither does one attack of the disease absolutely prevent another. Jenner himself relates the fact that Louis XV died of a second attack of the disease; and in the smallpox hospital at Boston in 1885 a patient had the disease three times in eight months. But these are the exceptions, and not the rule, by any means.

Since reaching the subject of vaccination abruptly, although I had intended noticing it under a special head, I may as well now as later on declare that in my humble judgment the discovery of the prevention of smallpox by vaccination is the most brilliant achievement ever attained by anyone in the science and practice of medicine, before or since. And I believe thorough vaccination, repeated every five to fifteen years, will prevent smallpox just as often as having the disease once will prevent a second attack. In my experience I have never seen a case of smallpox in any person who had been successfully vaccinated in ten years.

Of the six hundred cases at the hospital last year, ninety-five per cent. were colored, and of these eighty-five per cent. were males. Not more than five per cent. of the whole were children, for the reason that in Memphis all children must be vaccinated before they are admitted into school. The white people are much more commonly vaccinated than the negroes, and the city board of health find it much easier to vaccinate the colored women than the men. Hence the ratio.

Dr. Cyrus Edson, chief inspector of contagious diseases of New York City, in his report of 1890, said: "The first question asked by our inspectors of one sick with a suspicious case is, 'When were

you successfully vaccinated?' If the answer is in five or six years, the disease is not believed to be smallpox." He says further: "During nine years of service in the health department of New York, I have never seen a case of smallpox in a person who had been successfully vaccinated within five years, and never saw but one inspector contract the disease, and he was the only inspector who disbelieved in vaccination and refused to be vaccinated."

Of course the value of vaccination is accepted by almost the entire world of medicine and by everybody else who does not spell constitution with a K. I will report a case or two illustrative of the protection by vaccination.

In the outbreak of 1895 one of our inspectors found a colored man with a confluent case at the beginning of the pustular stage in one room, and in an adjoining room was a woman with a similar case. In the same bed with the man was his wife and an infant four days old. I visited the place, and found that the woman had been successfully vaccinated on both arms a few years previous. The whole lot were sent to the pesthouse, and the man and the woman from the adjoining room died; the infant contracted the disease and died, but the mother remained a month at the hospital without contracting the disease, and is still living.

About the same time a negro child, four years old, was found with confluent smallpox in a cabin with two older children and the father and mother. The parents had been vaccinated thirty years before, and both had at the time the mildest varioloid. The older children had been vaccinated two years previous, and they slept in the same bed with the younger one. The parents and child with the disease were sent to the pesthouse, and the parents recovered, but the child died. The other children were left in the house and slept in the same bed, but neither of them ever developed a symptom of the disease.

I could mention many similar cases if space permitted.

An early positive diagnosis should be made of all suspicious eruptive diseases occurring, especially among the unclean, unvaccinated negro population. If there is no one conveniently near by who is competent, get an expert and take no chances. Under such circumstances I would urge local boards of health everywhere to isolate, disinfect and vaccinate as the only hope to escape stampedes, the closing of public schools, stagnation of business, and the

expenditure of large sums of money. We had better make a hundred mistakes than one blunder. Besides, the day has come and gone when it is considered, either by the profession or the laity, discreditable to err on the side of safety. The medical profession generally should stand by boards of health everywhere in taking precautions against this disease, instead of, as is sometimes done, criticising them. I am not, and have never been, in favor of the idea of the least suppression of facts from the newspapers and the public, for fear of hurting commercial interests. Whenever such a course is pursued, and the fact leaks out, as it usually does, that health authorities are suppressing facts about any contagious disease in any place, there is always more or less of a stampede, and more damage is done to commerce than the publication of early facts would have caused.

As to the treatment of variola, very little need be said. My experience convinces me that the disease runs a definite course always. The mild form needs no medical treatment at all, and the severer forms are influenced but little by treatment. The patients should be kept in well-ventilated and clean wards. I believe the old idea of keeping patients hot is erroneous, as our best results have been with people treated in tents. I have never seen any plan of treatment prevent pitting, and have seen cases seemingly similar in age, color and severity of symptoms treated by exactly the same plan with very different results. In our hospital I usually give a purgative or laxative to begin with, and if the temperature is high I control it with cold sponging or a few small doses of phenacetin; nourish with milk and broths, and cold water is usually freely given. Diarrhea, which occurs in many cases, is treated with some mild remedy, such as paregoric. Secondary fever is treated as any septic condition should be.

In conclusion. I know of no disease to which the old adage "an ounce of prevention is worth more than a pound of cure" is so applicable as smallpox. And as a representative of the public health in West Tennessee, I beg of every member of the profession to help adopt this maxim.

Illustrating Dr. Buford's paper on Elephantiasis of Scrotum.

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ELEPHANTIASIS OF SCROTUM.

BY G. G. BUFORD, M.D.
MEMPHIS.

The accompanying pictures are photos taken of a laborer who presented himself to the U. S. Examining Surgeon's Board for examination, alleging disease of the scrotum. His penis measured 10 x 12½ inches and scrotum 10 x 13 inches. He gives a history of cystitis following exposure. There were present cicatrices over the perineum, scrotum and pubes. Urine was passing involuntarily from a fistulous opening in the upper anterior part of scrotum.

Elephantiasis is the result of irritation, the legitimate sequence of which is hypernutrition. Wyeth gives the history of several cases. The condition is rare in this climate, though common in tropical countries. Ablation is the only cure. Surgical interference was tendered in this case, but respectfully declined.

Masonic Temple.

IMPORTANCE OF EARLY DIAGNOSIS OF ADENOID VEGETATIONS.*

BY M. A. GOLDSTEIN, M.D.
ST. LOUIS, MO.
Professor of Otology and Laryngology, Beaumont Hospital Medical College, St. Louis.

Adenoid vegetations, hypertrophy of the pharyngeal or Luschka's tonsil, and enlarged third tonsil, are all equivalent terms indicating hyperplasia of the glandular structure in the vault of the pharynx. The importance of the early recognition of the pathological condition designated by these terms is a vital question in the etiology of diseases of the ear.

About 1860 Czermak, Turck, Lowenburg and Voltolini reported cases in which this tissue overgrowth had been observed. The real significance of this pathological condition and its numerous dire sequelæ, however, were first prominently brought to the attention of the profession by Meyer, of Copenhagen. In 1870 Meyer pub-

* By special arrangement this article will appear simultaneously in THE LANCET and THE STYLUS.

lished his classical treatise on Adenoid Vegetations in the *British Medico-Chirurgical Transactions*, and presented his researches to the profession in England.

Several years elapsed, however, before the great value of Meyer's careful research received the endorsement which it so richly merited. As the value of these observations became more generally known, a new era in the history of otology was developed. If it were only the recognition of a new pathology of the pharynx which the classical treatise of this eminent Northern observer brought to light, the diagnosis and treatment of this hypertrophied tissue would simply have been classed with the many other progressive factors in surgical science. In the light of modern pathology, however, we recognize in the discovery of adenoid vegetations and the proper methods advocated for their removal, perhaps as great a factor in this special field of medicine as the introduction of laparotomy in surgery.

When we consider that recent statistics indicate that from 50 to 75 per cent. of all cases of deafness are either complicated with or originally caused by this hyperplasia of the tissue in the vault of the pharynx, we no longer question the harmful influence which this hypertrophied tonsil tissue exerts upon the organ of hearing. In an examination of the inmates of an institution for the deaf and dumb, Wroblewski found hypertrophy of the pharyngeal tonsil in 92 out of 160 cases (57.5 per cent.); Lemcke found adenoids present in 58 per cent. of the deaf mutes whom he examined; Peisonn, 50 per cent. in 100 patients examined in a Parisian asylum; Frankenberger, in an examination of 158 inmates of the Prague Deaf and Dumb Asylum, found hypertrophy of this glandular tissue in 94 (59 per cent.) On the other hand, of many patients not deaf mutes who are suffering from various diseases of the ear, Halbeis found 53 per cent. with marked hypertrophy of this tissue, and Meyer 75.8 per cent. Another picture to illustrate the evil influences of adenoid tissue on the ear is indicated in a report by Arslau, of Padua. In the *Journal of Laryngology* he reports an examination of 4080 patients suffering from diseases of the throat, nose and ear, in 426 of whom adenoids were found (10.4 per cent.); of this number 251, or 59 per cent., were the victims of some form of ear disease.

In the light of these investigations it is well to occasionally sound a note of warning for an early recognition of these obstruc

tions in the vault of the pharynx, and to urge a careful examination of all patients in whom these conditions may be suspected. The diagnosis of this condition presents but few difficulties. Simply an understanding of the results of nasal obstruction, together with acuteness in observation of the facial expression and an appreciation of the value of general diagnosis, are necessary to definitely establish the presence of adenoid growths. Normally the lymphoid tissue in the vault of the pharynx is incorporated in the mucous membrane, and scarcely elevated above its surface. It is this lymphatic tissue of the pharyngeal tonsil which is involved in the hyperplasia and hypertrophy, which so readily fills the naso-pharyngeal cavity.

The most susceptible period for the development of adenoids is the period of adolescence, the ages between five and sixteen, when the lymphatic cavities of the system are most pronounced and when similar influences extend to the lymphoid tissues of the pharynx. These young patients present the following clinical picture: The first thing that impresses the medical observer is a peculiar anxious expression about the face of the patient, a pinched, drawn-up nose, mouth constantly open and lips parted, eyes abnormally dilated; the entire facial expression usually appearing as one of stupidity and dullness. The breathing is labored, frequently accompanied by a rattling caused by accumulations of mucus in the naso-pharyngeal area.

These are the landmarks accompanying adenoid growths due to the mechanical obstruction of the naso-pharynx and the efforts made by the patient to breathe physiologically through the nose. The complexion is sallow, and a general lacking of tone and nourishment of the system is apparent. The little sufferers sleep restlessly, usually with the mouth wide open and snoring lustily. Here also a normal function of the body is disturbed. The air we breathe should be inspired through the nose, where it is properly moistened, warmed and filtered before reaching the lower respiratory tract. Where hypertrophied adenoid tissue obstructs nasal respiration, the air is inhaled through the mouth, reaching the lungs unpurified, unmoistened and in an unfavorable temperature. These unfavorable conditions are responsible for the stunted growth and impaired physical development of this class of cases.

A feature of prime importance, however, and perhaps the most

serious sequel in the consideration of this subject, is the obstruction in the naso-pharynx in its relation to the organ of hearing. As the hypertrophied adenoid tissue in the pharyngeal vault and wall progresses it soon encroaches on the lateral walls, where the pharyngeal orifices of the Eustachian tubes are found. It requires but little of this soft, lymphoid tissue to completely conceal the orifices of the Eustachian tubes and thus deprive the middle ear cavity of its natural ventilation and source of air supply.

As a natural consequence of the depletion of air from the tympanic cavity, the drum membrane collapses, the functioning of the entire conducting apparatus of the ear is seriously impaired, and deafness is the result. If the adenoid tissue responsible for this obstruction and functional derangement is neglected for a number of years the evil influences brought to bear on the ear become permanent, and marked deafness results. This has oftentimes been proven by radical operative procedures for the removal of adenoid vegetations in adults suffering from deafness. While in some instances these operations are attended with some diminishing of the deafness, yet, in the bulk of cases thus operated upon, the relief has come too late.

It is imperative, therefore, to institute measures for the eradication of this adenoid overgrowth at the earliest possible opportunity. To confirm the diagnosis as presented by the appearance of the patient, there are two methods at our disposal: 1, the inspection by reflected light of the naso-pharynx; and 2, digital examination. Examination with the post-nasal mirror is often unsatisfactory in young patients, where fretfulness and restlessness prevent a careful inspection, and where the introduction of tongue depressor and mirror easily cause gagging. Physicians should urge the parents of all children to an early training in this direction. When the family doctor presents himself before the little patient, spoon or tongue depressor in hand, he should not meet with the usual vociferous resistance so universally accorded him. A child should be taught to open its mouth wide to permit an easy inspection of the fauces, tonsils and adjacent structures which are so frequently involved in the throat complications of exanthemata and other diseases of childhood, presenting lesions or infection of this area.

By far the most satisfactory verification of the presence of adenoid growths is the digital examination of the naso-pharyngeal

space. Briefly, this is accomplished in the following manner: a short section of rubber tubing, a heavy nipple finger cot with the closed end cut off, or a metal finger guard should be slipped well over the index finger of the operator's right hand to protect it from the teeth of the patient during the examination. As an additional safeguard, the mouth should be kept well open by some form of mouth gag, and the patient firmly fixed and held by an assistant.

A simple procedure to check the struggles of the patient is to wrap a sheet about the body, thus pinning the arms to the sides; the legs should be fixed by the legs and knees of the assistant, who sits in a low chair with the patient on his lap; the head must be steadied in an erect position. The operator now passes the finger, previously well cleaned, quickly to the back of the pharynx with the palmar side of the hand uppermost. The finger then glides upward back of the soft palate, following the line of the posterior wall of the pharynx to the vault until the outlines of the naso-pharynx can be explored. The finger then makes an excursion laterally right and left, sweeping over the entire surface of the pharyngeal wall and vault, and if hypertrophied adenoid tissue is present this is encountered and presents to the touch a peculiar soft, yielding and irregular mass, which has been frequently described as the "sensation of touching a mass of earth worms." This overgrowth of adenoid tissue may also be compared to a mass of soft, cauliflower-like granulation tissue.

There is but one successful method advocated for the treatment of this condition, and that is its surgical extirpation, and the sooner the physician advises this procedure the greater will be the service rendered the patient. It is not the province of this paper to consider the technique of the removal of adenoid growth, but simply to impress the physician with the importance of this pathologic lesion in the naso-pharynx and the grave complications which may involve the organ of hearing and the general health of the patient if a prompt removal and active arrest of this hypertrophied lymphoid growth is not carried out. By overlooking this naso-pharyngeal obstruction in the early stages of its development, we are jeopardizing the hearing, health and happiness of our young charges, and this plea is offered in their interest.

REPORT OF A CASE OF PSEUDO CYESIS.

BY ALFRED MOORE, M.D.

MEMPHIS.

Young girls who have a good reason to fear pregnancy, and married women who ardently desire to be pregnant, are apt to imagine themselves *enciente* when they are not. These women will sometimes present all of the subjective and some of the objective symptoms of pregnancy that will not only deceive themselves, but will sometimes mislead the physician also, if he does not make a careful examination.

Hirst mentions a case that was sent to the Philadelphia Hospital to be delivered, the physician who sent her there having made the diagnosis of pregnancy at term. She was examined carefully at the hospital and the abdominal distention was found to be due entirely to tympanites, due to partial obstruction of the sigmoid flexure, which was involved in adhesions of the uterine appendages caused by a peritonitis nine months previous.

The following case occurred in a young girl, who I might properly describe as hysterical and weak-minded:

At the time I first saw her she was suffering with a pelvic peritonitis and gave a history of absence of menstruation following intercourse, nausea, vomiting, enlargement of breast and abdomen. She firmly believed that she was pregnant, and on inspection, the breast and abdomen certainly looked like she was pregnant. I was unable to hear fetal heart or make a digital examination on account of the pain and tenderness present.

The family were very anxious for a positive diagnosis, but I had to admit that I was unable to make a positive diagnosis of pregnancy and that they would have to wait. In ten days the temperature which she was having subsided and I attempted to make an examination with the patient on the table. She believed that she was about five months pregnant but had not felt quickening. The hymen was ruptured and the vagina inflamed. There was still too much inflammation to make the bimanual examination, and I told the family that they would have to wait several weeks longer, as I was unable to say positively whether she was pregnant or not. At the end of three weeks I examined her again and found temperature normal, pulse normal, nauseated, could not wear corset or skirts around waist, breasts continued to attract attention. She felt no movements but firmly believed that she was pregnant. The abdomen was swollen and tympanitic. I could not hear heart sounds nor could I feel womb or fetus by external examination. By conversing with her about different things foreign to her case, I was enabled to make a digital examination and the cervix and womb were found to be small and about the normal size. The tubes and ovaries were tender on pressure.

It was hard to convince her that she was not pregnant, but as soon as I succeeded in convincing her of the fact that she was not, her periods returned almost immediately. Since, she has had one or two cramping spells with nausea, but her periods have returned twice and she does not now believe that she is pregnant. I have not had an opportunity to make a digital examination lately, but learned from the family that her periods have returned regularly since this was reported.

Weir Mitchell has noticed that the symptoms and signs of pregnancy rapidly disappear in these cases when the woman is once fully convinced of the fact that she is not pregnant.

The writer was once invited by two internes to witness a labor. The woman was about 35 years of age and looked to be pregnant. She had then been in labor for a considerable time and no progress made. About this time one of the professors came along and examined the woman and found that she was not pregnant, and that her condition was due to tympanites and fat.

CORRESPONDENCE.

ATLANTA, GA., January 25, 1900.

Editor Memphis Lancet:

DEAR DOCTOR—I have just read Dr. Ellett's article in the Memphis LANCET on the prevalence of certain eye, ear, nose and throat diseases among the negroes. I enjoyed reading the article, and in the main my experience agrees with his. There are two points, however, where we differ.

First, in regard to the occurrence of squint in the negro. There is hardly a year which passes when I do not operate on from three to four cases of squint in the negro, and that too in the full African type. Internal strabismus is the most frequent type, yet I have also operated on the external forms. I consider squint among the negroes as by no means infrequent. I can scarcely see how there can be such a difference in the experience of various Southern oculists, and Dr. Ellett's statement was indeed a surprise to me.

Second, in regard to adenoids in the negro. I have operated on seven cases of adenoids in negro children during the last three months at my clinic at the Atlanta College of Physicians and Sur-

geons. Nor has this been an unusual experience. The adenoid tissue removed from these cases was as large as is usually found in any other class of patients. The fact is, I have come to look for adenoids in the negro as often as in the white. It may be that climate and altitude have something to do with this, and yet it is hard to see why my experience does not agree with that of other Southern laryngologists.

Another fallacy quoted in the various textbooks on the eye was promulgated by Dr. Burnett, of Washington, and that is in regard to the non-occurrence of trachoma among the Southern negroes. My experience shows that true trachoma is exceedingly rare among all classes in the South, but that it occurs just as frequently among the negroes as among the whites. I mean that I have seen true cicatricial tissue in the lids as the result of this disease, although I have never seen it produce entropion of the lid.

Remember, I am not criticising the results of Dr. Ellett's observations, but am simply giving you my experience here in Atlanta.

Very truly yours, DUNBAR ROY, M.D.

CONCERNING CONVERGENT STRABISMUS.—Roosa (*Post-Graduate*, Dec., 1899) says that we have finally learned that strabismus is an affection that, in order to cure, is to be taken seriously. It should be treated as soon as it is recognized, if possible, even if it be at the early age of 2 or 3 years. An operation is the last resort when we find that exercise, with occlusion of the fellow eye and correction of the refraction will not remove the deformity. When the operation has been performed, the patient should always be kept in the hospital or in-doors for at least twenty-four hours after the operation. Finally, the patient should not be lost sight of, until it is certain that all that is possible has been done not only to restore the normal action of the muscles, but also binocular single vision. That the latter is not more frequently accomplished is because the subjects are not seen early enough, and not treated thoroughly to the end.

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EDITORIALS.

WHAT MAN AND THE LOWER ANIMALS OWE TO VIVISECTION.

A bill prohibiting vivisection in the District of Columbia has been introduced before Congress by Senator Gallinger, which, should it pass, will establish a precedent for similar action in all the State Legislatures of the Union; bring the good work done by the Bureau of Animal Industry and Marine Hospital Service to a standstill, as well as embarrass and severely cripple medical research, thought and opinion in the United States. The emotional element in man is strong, and fearing that this element will be directly appealed to by the eloquent Senator, who is a homeopathic physician, a fact which will give his utterances on the subject the stamp of authority, and fearing also that such an appeal from such a source might be made to overshadow the question of the utility of vivisection, we have gone to the trouble to demonstrate, by compiling a few facts, what man and animals owe to this practice.

Evolution is a slow and insidious process, and medicine had been no exception to the general law until 1857, when Pasteur demonstrated the development and germination of organized elements as the real cause of all fermentation. A new world was then opened to science, and Lister immortalized himself and Pas-

teur's discovery by giving to the world that blessing of blessings—antisepsis. Prior to this time the theory of spontaneous generation was the accepted one.

> "By this sure experiment we know
> That living creatures from corruption grow."

Although in 1668 Francesco Redi cast serious doubt upon this speculation, it remained for Pasteur to upset it completely by a series of most beautiful and decisive experiments by which he demonstrated beyond cavil that sterile liquids remained sterile indefinitely so long as no germs were introduced into them, and that *living germs* existed everywhere. This was the true birth of the microbic or parasitic theory of disease, and Listerism or antisepsis was the natural outcome of it.

In 1863 Davaine, stimulated by Pasteur's researches, after numerous inoculation experiments, demonstrated that the bacillus anthracis was the causal factor of anthrax. In 1873 Obermier demonstrated the contagium of relapsing fever. In 1877 Weigert introduced staining of the then known bacteria, but in spite of this the profession were slow to accept the microbic theory of disease until 1875, when Lister demonstrated to the world the relationship existing between micro-organisms and inflammation and suppuration. In 1878 Koch published his "Infectious Diseases of Wounds." In 1879 Hausen found the bacillus of leprosy and Neisser found the gonococcus.

In 1880 Eberth observed the typhoid bacillus; Pasteur published his work on Chicken Cholera, and Sternberg described the micrococcus Pasteuri (pneumococcus of Fränkel). In 1882 Koch demonstrated the tubercle bacillus; Pasteur published a work upon Rouget du Porc, and Loffler reported the discovery of the bacillus of glanders. In 1884 Koch discovered the comma bacillus—the cause of cholera; Loffler the diphtheria bacillus, and Nicolaer the tetanus bacillus—the cause of lockjaw.

In 1892 Pfeiffer discovered the bacillus of influenza (la grippe), and in 1894 Yersin and Kitasato independently isolated the bacillus causing the bubonic plague. This practically demonstrates the history of modern medical advancement. The question now naturally suggests itself: what has all this to do with vivisection? The answer is plain. Bacteriology is the *science* whose principal objects are to discover the cause, prevent dissemination, and prepare the

way, for the cure of diseases. Koch's law, which briefly demands that a specific microbe be always associated with a specific disease; that this specific microbe must be demonstrated and capable of reproducing the disease in another animal through inoculation, makes vivisection absolutely essential to further progress, and we contend that further progress is necessary for the benefit of man as well as animals. Our task then is to prove our contentions to be correct. We will therefore state "our case" first, then consider the main arguments brought forth by our opponents, and lastly disprove these arguments.

Since the fourteenth century about 25,000,000 lives have been lost by the bubonic plague. Two years ago Prof. Haffkine utilized twenty rats, the disseminators of the infection, in the hope of demonstrating the virtues of a protective serum which he had formulated. Ten of these rats were inoculated with the serum and ten were not; of the uninoculated nine died with the disease, of the ten rendered artificially immune only one contracted the disease. In lower Daumann 2197 persons were inoculated with Haffkine's protective serum, 6033 remaining unprotected; of the latter 1482 died, of the former only 36 died.

The only parallel to this is the treatment of diphtheria with antitoxin, whereby 50,000 (a safe estimate) lives are saved annually the world over. In the days of the Empress Catherine of Russia 2,000,000 people died of smallpox in a single year in the Russian Empire. In 1707, in Iceland, out of a population of 50,000, 1800 died. In Mexico, in the sixteenth century, 3,500,000 died of the disease.

In Sweden, before vaccination, the deaths per 1,000,000 population were 2045; since compulsory vaccination was introduced the rate has fallen to 155. In England, during the eighteenth century, the average deaths per 1,000,000 were about 2000; since the enforcement of vaccination it has fallen to 53 per 1,000,000. The modification of this law, however, has so much increased the number of cases of smallpox that the people are now again clamoring for free district vaccination. From personal experience we can speak of the great value of vaccination from the lessons learned in the greatest of all modern epidemics—the epidemic in Montreal, Canada, in 1885. The greatest lesson taught, however, is the one of the Franco-German war. The latter were protected by vaccination and

re-vaccination, and had but 261 cases; the former were not so protected, and had 23,469 cases. Yet even today, and in the city of Memphis, we find men of intellect, rabbis and scholars, still clinging to the dread of dangers that have long since passed—to the ancient prejudices that should have ceased when arm-to-arm vaccination ceased. The preparation of vaccine virus, diphtheria antitoxin and Haffkine's protective serum against bubonic plague, all require vivisection. Is it right to deny mankind these benefits?

In 1882 Koch discovered the tubercle bacillus, and in 1888 tuberculin was given to the world. While this has not met the expectations of the world as a curative measure, it nevertheless remains the only means of diagnosticating "consumption" in its earliest stage in man and animals, a fact of the utmost value from the hygiene standpoint. The value of this knowledge to stock raisers is immeasurable, to say nothing of the satisfaction it may afford a few anti-vivisectionists and ourselves to know that the danger of ingesting tuberculous meat and giving their little ones and our little ones tuberculous milk is reduced to the minimum.

A few figures as to diphtheria may also be of interest. Welch investigated 7166 cases from 80 different sources, showing a mortality of only 17.3 per cent. after antitoxin treatment, or a diminution in mortality of 55 per cent. This mortality has since been greatly reduced. The different mortality rates according to the date of commencing treatment is almost startling. We give the exact figures from *Johns Hopkins Bulletin*, 1895:

Day.	Mortality.	Day.	Mortality.
First	18.3	Fifth	67.0
Second	22.7	Sixth	67.4
Third	38.1	Seventh	72.5
Fourth	53.6	Eighth	81.6

Could figures be more eloquent in their appeal for the earliest possible use of a remedy? In the first investigation of the American Pediatric Society there were nearly 6000 cases investigated in the practice of 615 physicians in Canada and the United States. The mortality was 12.3 per cent; 218 of these cases were moribund when injected, but are included in the mortality report. In over 4000 cases, in which the treatment was begun during the first three days, the mortality was only 4.8 per cent.

In the report of 1897 it is stated that "before the introduction of the serum treatment, 90 per cent. of the cases of laryngeal diphtheria required operation; after its introduction, only 39.2 per cent. Before the serum treatment was introduced recovery took place in 27 per cent. and death in 73 per cent.; after the serum treatment was introduced the figures were precisely reversed; recovery took place in 73 per cent. and death in 23 per cent. Well may Prof. Jacobi say that diphtheria treated with antitoxin within twenty-four hours should have no death rate.

Prior to the use of Pasteur's antirabic serum no authentic case of cure from hydrophobia had been reported. The mortality was 100 per cent.; today it is less than 1 per cent. Vivisection is necessary for the production of the immunizing agent. Mention might also be made of trichinosis, of cholera, of typhus and typhoid fevers; of yellow fever, and a host of other diseases, as showing the utility of vivisection.

And as marking our acknowledgment of the debt we owe to the lower animals for the service they are to us, we need only mention the studies that have been undertaken in their behalf by the U. S. Bureau of Animal Industry as to anthrax, hog cholera, swine plague, Texas fever, actinomycosis, tuberculosis, glanders, etc., etc. $25,000,000 was the estimated saving to stock breeders in 1897 in the United States by these investigations, which naturally implies that a vast number of animals were saved from suffering and from death. Do the anti-vivisectionists object to the saving of this vast amount of suffering and death?

"The Case Against Vivisection," by Mark Thornhill, Esq., London, 1899, is as strong an argument as we have seen put forth, but like all their other arguments it is a well-planned effort to belittle the past and present efforts of doctors, sanitarians and veterinarians. We have read this book of 145 pages together with other literature bearing upon this phase of the subject, and for argument's sake we grant everything that they say, although it is only just to state that a compilation of greater misstatements we have never seen. The operation of tracheotomy is referred to as "slitting of the windpipe." The researches of Golz and Ferrier on brain localization are characterized in the harshest language as, "holes bored in the skull, * * * brains pumped out, pulled out with pincers, burned out with corrosive acids and hot wires." They fail to state

that direct irritation of the brain is painless, and even if this were not so, anesthetics were unquestionably employed; for were they not, the voluntary movements would be apt to mask the involuntary movements resulting from the electric stimulative which was always employed first to demonstrate the existence of the center in the animal experimented upon before the center was removed. The researches of Wood on the effects of high temperature (120° to 190°F) on the brain and locally on the nerves are characterized as "dogs burned, baked and flayed alive." They fail to state that these experiments made clear the treatment of heat stroke and sun stroke. On page 40 the author says, referring to positive benefits derived from the practice of viviseetion:

"I have been able to find no more than six. These are:

1. The modern treatment of aneurisms.
2. The modern system of securing arteries after amputation.
3. The cure of neuralgia by dividing the nerves of the face.
4. The transfusion of blood.
5. The antiseptic treatment after operations.
6. Nitrate of amyl as a palliative in attacks of angina pectoris."

Surely we cannot be accused of overstating our case when in giving our side of the discussion we completely ignore five of these admitted six benefits and only refer to one—antisepsis—as the blessing of blessings. We will not burden our readers by even attempting any figures to show the good of any of the six benefits admitted by our opponents.

The professional sentimentalists, these self-appointed guardians of the welfare of the lower animals, are false to the trust they seemingly are trying to foster and protect; for had they their wish, the various cattle plagues would carry off their countless thousands and cripple the largest industry of the world, to say nothing of the loss of life entailed by the dissemination of some of these diseases among man. M. G.

REPORTS OF SOCIETIES.

PROCEEDINGS OF THE MEMPHIS MEDICAL SOCIETY.

Regular Meeting, February 6, 1900.

The President, Dr. E. C. Ellett, in the Chair.

Present were: Drs. Black, Barton, Reilly, Henning, Buford, Kane, Alfred Moore, W. B. Sanford, W. S. Haynes, Rudisill, Andrews, Haase, Ellett, Heber Jones, Williams, Wolff, Braun, Raymond, Gardner, Rice, Jelks, Crofford, Krauss, Stanley, Goltman, Venn, and Moore Moore.

Dr. Alfred Moore read a *Report of a Case of Pseudo Cyesis.* (See page 126.)

Dr. J. L. Andrews said that while such cases were not uncommon in literature he had never seen one.

Dr. Heber Jones mentioned a case occurring in a very fleshy Jewess at the time of the menopause. A scanty, irregular menstruation occurred during the supposed pregnancy. There was nausea, and the woman said she felt quickening. When labor was due he was called, and informed her of her mistake. The woman has never menstruated again. There was no uterine disease, and the symptoms were due to mental impressions.

Dr. W. B. Sanford has seen three cases. Two of the women were averse to becoming pregnant. All the subjective symptoms were present, and one woman thought she was in labor. He would like to know the pathology of these cases. He thinks they are usually due to some uterine lesion, and not to the imagination; but if due to a uterine lesion he does not think menstruation would be reëstablished. He has known of two other cases in women over 40.

Dr. J. L. Barton thinks Dr. Moore's patient might have been pregnant, and aborted before the final examination was made.

Dr. Alfred Moore does not think this could have been the case, though he thought of it, for the woman still thought she was pregnant till he assured her to the contrary, when the symptoms rapidly disappeared. Though there was some pelvic inflammation present, he thought the symptoms in this case were due to the imagination.

Dr. F. S. Raymond read a paper on *Smallpox.* (See page 114.)

Dr. Heber Jones said that the prevailing disease, though mild, was undoubtedly smallpox. In Louisville last year the death rate was less than 3 per cent. Our observation disproves Dr. Happel's statement that vaccination does not protect from the prevailing disease. An instance was mentioned where smallpox appeared in a house in which seven negroes lived, only one of whom had been vaccinated, and he alone escaped the disease. Some of our cases are so mild as not to make the patient sick after the primary fever, and the period of detention in the hospital is shorter than ever before.

Dr. J. L. Barton asked if successful vaccination of the parents conveyed any immunity to the children.

Dr. Marcus Haase said that as secretary of the board of health he had seen 1084 cases of smallpox, "pseudo smallpox," and "Cuban itch," all of which he thought was true smallpox. Successful vaccination usually immunizes. Personally he has never been successfully vaccinated and has never had smallpox and believes himself to be naturally immune. Second attacks of smallpox rarely occur, but he has seen it once, the two attacks being within nine months. He has seen a woman with smallpox delivered of a dead child bearing the eruption. Another woman contracted it two days after delivery and the child never had it. Several instances were reported where smallpox attacked families, the vaccinated ones escaping. He has seen smallpox and chickenpox occur at the same time, in the same individual, and has seen it follow measles so closely that the eruption of measles had not faded. He does not think vaccination of the parents after the birth of the child protects the child. In January 222 cases were reported to the board of health. In February 12 or 13 cases have been reported. The disease is lessening in frequency.

Dr. Alfred Moore asked why our cases are not reported to the Marine Hospital Service.

Dr. Haase said they did not have to be, but were, and the last report of that service showed 132 cases up to January 19.

Dr. B. G. Henning said he thought vaccination of the mother during pregnancy would protect the child from vaccination and from smallpox, and this would explain natural immunity. He saw a woman who was nursing a smallpox patient give birth to a child

with the eruption in the pustular stage. It is claimed that vaccination done in the papular stage of smallpox will abort the disease, and he thinks he has seen this occur. Stretching the skin does not cause the smallpox eruption to disappear as it does that of measles, etc.

Dr. T. J. Crofford asked if it was proper to excuse pregnant women and syphilitics from being vaccinated, and also asked on what do anti-vaccination societies base their opposition.

Dr. Jos. Venn asked if we could tell anything about the probability of immunity from the looks of the scar. His idea is that the large scars are due to mixed infection (streptococcus).

Dr. Henning said he was successfully vaccinated forty-two years ago and it has never taken on him since, nor has he contracted smallpox.

Dr. G. G. Buford agreed with Dr. Venn that infection with pus micro-organisms causes the large scars following vaccination. In England a "conscientious objection" will excuse a person from vaccination.

Dr. Heber Jones said this was not formerly the case. When a pregnant woman is vaccinated with pure virus there is no danger, but a mixed infection might cause an abortion. He has not seen any bad effect follow vaccination in syphilis. A small pitted scar offers better protection than the big smooth ones. He has a small one from a successful vaccination in infancy and has never had it to take since. He thinks successful vaccination often affords permanent immunity. Negroes will try to wash off the vaccine of the vaccination, and at the board of health they do not dismiss them until the virus is dry. The board vaccinated 23,000 people in 1898 and 26,000 in 1899, about 90 per cent. of them being successful. They make their own virus and have it fresh and strong.

Dr. Wm. Krauss said that the young of animals infected with toxins were immune to those toxins only as long as they nursed, and the young of other animals were also immune while nursing an animal who had been inoculated.

Dr. Haase does not believe that smallpox can be aborted by vaccination after the eruption appears. He has seen it tried in three cases and the vaccination did not take. Vaccination after exposure will protect from or greatly modify the disease. He has seen smallpox in one man with a good scar thirty-two years old and in another

where the scar was twenty years old. In one case varioloid appeared fourteen days after successful vaccination. He has seen the stage of incubation last fourteen and twenty-one days.

Dr. Raymond said that Dr. Happel's apparent exceptions to the immunity afforded against "pseudo smallpox" by vaccination were very few and were probably cases of great susceptibility. He has seen the eruption apparently vesicular from the first. He does not see any use in vaccinating after the disease appears. He agrees with Dr. Jones about the scars, but does not think that mixed infection vitiates the effect of the vaccination.

A vote of thanks was tendered Drs. Raymond, Jones and Haase for their contributions to the meeting.

Dr. E. D. Mitchell was elected to membership.

A resolution was passed expressing the sympathy of the society to Dr. E. P. Sale at the outcome of a damage suit against him and also the confidence of the society in his professional ability and personal character.

The internes of various hospitals in the city, were, by resolution, granted the privileges of the society.

PROGRESS OF MEDICINE.

General Peritonitis and its Treatment.—The subject of the treatment of general septic peritonitis is always one of interest, although we know that we are almost invariably fighting a losing battle. One of the commonest causes of this as well as other forms of peritonitis is disease of the vermiform appendix, so that we are thus able to speak properly of a form of appendicular inflammation with general peritonitis, characterized by a set of symptoms whose presence almost at once destroys hope in the mind of the surgeon. Cases are reported from time to time, of recoveries from this condition after operation with extensive peritoneal irrigation, usually with surgical salt solution and subsequent free drainage. The method is not entirely satisfactory even when successful, and the results are not always to be accepted without reserve as cured cases of general septic peritonitis, because it is often the case that a very considerable fraction of the peritoneum is not involved at all in the

disease, in spite of clinical appearances, and may even have escaped contact with the irrigating fluid used at the operation. One of the most unsatisfactory parts of the question is that concerning safe and efficacious drainage. The rapidity with which peritoneal adhesions form around such a focus of irritation as that caused by a strand of gauze packing is well known, but the effect of this process upon the perviousness of the drain has perhaps not received the attention it deserves. The aim of the operator has always been to remove as much as possible of the inflammatory products by irrigation, and then to provide efficient drainage for a period of at least forty-eight hours. It has been recognized that it is not possible to disinfect the peritoneal cavity, but there has always been hope that the peritoneum would be left in a condition to cope with the remaining infectious matter, and would take care of any new septic products which might be formed. The peritoneum has been trusted to great lengths in this regard by some operators, and in some cases after free irrigation with salt solution and local cleansing of the site of infection, the abdomen filled with hot salt solution has been entirely closed. Successes have been reported after this method, though we hesitate to say in consequence of it, for the question of the actual extent of peritoneum involved is not always easy to settle, though this has an important bearing on the future of the case. If the peritonitis is actually general, the alexic function of the whole peritoneum is practically lost, and we should be justified in thinking that mere dilution of the poison would not prevent its entrance into the circulation. Furthermore, we must remember that by the time a true general peritonitis has developed, the human organisms must already have absorbed a considerable quantity of toxins which have begun their harmful work on the nervous centers with great promptness. In cases in which, at the time of operation, although clinically having every evidence of general peritoneal involvement, we find, in consequence of the lack of the customary adhesions, coils of more or less uninvolved intestine, the possibilities of a favorable manifestation of the protecting power of the peritoneum are very considerable, and it is under such circumstances, we think, that most of the so-called cases of peritonitis are cured.

We must remember that there are several elements in cases of general peritonitis which add to and in fact constitute the basis of the gravity of the disease, besides the condition of the peritoneal mem-

brane itself. There is more to do in fighting this disease than simply to remove the inflammatory products in the peritoneal cavity, and to prevent their reaccumulation. Tympanites from intestinal paresis, with the consequent absorption of toxins from the putrefying intestinal contents, is a very serious element in the disease, dangerous and unsatisfactory to treat. If this condition is well developed, it would be impossible to put any quantity of salt solution into the abdominal cavity and then close the wound. The consensus of opinion at present in regard to the disease under consideration seems to be that it is almost impossible to save a case of general peritonitis, and that our chances of success by what are now commonly accepted methods of treatment are inversely proportional to the extent of peritoneum involved. Surgeons are apparently pretty well agreed that it is best not to resort to general abdominal irrigation, if possible, and that in any case the cleansing of the peritoneum shall first be undertaken carefully and methodically from the point of infection outward. If we can ever have an apparatus to supply hot salt solution continuously, and thus establish the same system that has been used in joints, we might save some otherwise hopeless cases of general peritoneal inflammation; but, until we can, the weight of evidence seems to be that there must be some provision for drainage.—*Editorial in Medical Record*, Dec. 23, 1899.

Traumatic Rupture of the Liver, Kidney and Lung.—Alexander B. Johnson (*Annals of Surgery*, February, 1900) reports the case of a boy aged 7 years, who, while playing in the street, had been knocked down by a heavy wagon, one or more of the wheels of which had passed across the middle of his body. He was suffering from a marked degree of shock, his skin was cold and bathed in a clammy sweat, he was pale, his pulse was rapid and weak, and his respiration superficial. He vomited occasionally small quantities of clotted blood and mucus. There were no wounds of the skin except two abrasions upon the right side of the thorax near the clavicle. The abdomen was distended moderately, uniformly tender, and gave the signs of free fluid in the abdominal cavity. He appeared to be in a dying condition, and was stimulated by means of whiskey and strychnin hypodermically.

A median abdominal incision was made from the ensiform cartilage to the umbilicus. Upon opening the peritoneum considerable

fluid blood, with numerous small fragments of liver tissue, escaped. The alimentary canal was inspected throughout, but no rupture was found. Blood appeared to be flowing from between the upper surface of the right lobe of the liver and the diaphragm. Examination of the right kidney revealed a transverse rupture of the organ, which appeared to extend nearly through its entire substance. The peritoneum in front of the kidney was not torn, and the hematoma was so small as scarcely to be noticeable. The spleen and the left kidney were not injured.

The hand was introduced between the liver and the diaphragm, and a ragged tear was felt in the right border of the right lobe of the liver not far from the posterior surface of the organ. The suspensory ligament of the liver was then partly divided and the anterior border of the right lobe depressed. It could then be seen that the right lobe of the liver had been torn away from its posterior attachment to the diaphragm, leaving the extreme right portions of the right lobe still attached. The fissure between the two portions of the liver gaped widely; the edges of the fissure were extensively pulpified; the bleeding had almost ceased. The peritoneal cavity was thoroughly flushed with hot normal salt solution and dried with pads of gauze. The right border of the fissure in the liver was lightly packed with sterile gauze, which was led out over the upper surface of the liver through the abdominal wound; the liver was then pushed back into place and held there by a large wedge of sterile gauze pressed against its posterior border and lower surface. At this time the patient was in a condition of collapse, which was, however, relieved by an intravenous infusion of 1100 cubic centimeters of saline solution at a temperature of 118°F.

Upon the following day the entire right side of the patient's thorax was the seat of subcutaneous emphysema. Careful search failed to reveal a fractured rib. He coughed and expectorated small amounts of bright fluid and clotted blood from time to time.

He remained exceedingly weak, and was nourished chiefly by nutrient enemata for the first twenty-four hours. For three days his urine contained a moderate amount of blood. His temperature was moderately elevated for several weeks, and his pulse remained rapid, not becoming as slow as 120 until the tenth day.

Considerable oozing of blood persisted for several days into the dressing, which was followed by a bright yellow, thin discharge,

profuse in amount and suggesting eggnog in appearance. This resemblance was so marked that the child believed that the eggnog which he drank escaped immediately through the wound. It was thought possible that an opening might exist in the esophagus at its junction with the stomach, but methyl blue solution administered by mouth did not appear in the wound. Microscopic examination showed the discharge to consist of disintegrated liver tissue and pus, and chemical tests showed the presence of bile.

The convalescence of this patient was very slowly established. He remained delirious or semi-unconscious and apathetic for nearly one month; the large, deep cavity continued to discharge freely, and diminished in size very slowly indeed. He was not in an afebrile condition until one month after the injury. It was two months before the wound of the abdomen was entirely healed. He remained in bed until the end of six weeks, after which his nutrition improved rapidly, and he left the hospital one hundred and fourteen days after the injury, well nourished and physically active, with a comparatively small and firm abdominal scar.

Recurrent Spindle-Cell Sarcoma with Glandular Involvement, Treated Successfully with the Mixed Toxins.—Dr. Wm. B. Coley reports the case of a man 40 years of age, a carpenter by occupation. In September, 1896, he had first noticed a swelling in the parotid gland. This had gradually increased in size, until it was as large as an English walnut. It had then been removed by operation in March, 1897. It had quickly recurred, and had grown more rapidly, so that in May, 1897, a second operation had been performed, when it had been found impossible to remove the whole tumor. The latter had continued to grow, and by July, 1897, had involved the submaxillary gland. Having at this time been regarded as a totally inoperable case, the use of the mixed toxins of erysipelas and bacillus prodigiosus had been begun. Very little improvement having been noticed after three weeks of this treatment, the patient had been referred to Dr. Coley for advice and treatment. Inasmuch as only moderate doses had been given, and in view of the fact that the patient's general condition was sufficiently good to warrant giving very large doses, it had been decided to give this treatment a further trial. Physical examination at that time had shown a tumor occupying the entire left

parotid region, and extending from the left auditory meatus forward nearly to the angle of the mouth, and from the angle of the jaw nearly to the orbit. The tumor was circular in shape, and measured three and one-half by four inches in diameter. It was markedly protuberant and ulcerated in the central portion over an area the size of a silver half-dollar. Just beneath the angle of the jaw was a secondary tumor the size of a hickory nut. The tumor had every appearance clinically of malignancy and was hopelessly inoperable. The microscopic examination made had shown the growth to be a spindle-celled sarcoma. Daily injections of the mixed toxins had been made directly into the tumor, and the dose had been rapidly increased up to the point of giving a severe chill and a temperature reaction of 104° or 105° F. After about a week slight improvement had been noticed, as evidenced by diminished vascularity and decrease in size. This improvement had steadily continued, and the treatment had been kept up about ten weeks. At the end of this time the neoplasm had apparently disappeared, leaving a bright granulating area in the region of the ulceration. This had rapidly cicatrized, and a few weeks later the patient had been presented to the New York Surgical Society entirely free from any trace of the tumor. He had remained in good health up to the present time, nearly two years and a half since the beginning of the treatment.—*Medical Record*, Jan. 20, 1900.

The Significance of Intra-ocular Hemorrhage as to Prognosis of Life.—Charles Stedman Bull, M.D., N. Y., says:

"Summarizing what has preceded, the following conclusions have been drawn from my experience:

1. Hemorrhages into, and beneath the conjunctiva are of little importance in the young, as they usually occur as a result of violent muscular effort, as in coughing and long-continued sneezing. The vessels in the conjunctiva having little or no support in the loose connective tissue, readily give way to paroxysms of violent expiration. In the aged they occur spontaneously and point to a general weakened condition of the vascular walls.

2. Hemorrhages in the interior of the eye are always of prognostic significance. In senile angio-sclerosis retinal hemorrhages are very frequent and point significantly to the probable occurrence of cerebral apoplexy.

3. Recurrent retinal and subhyaloid hemorrhages in the young are of slight prognostic importance, especially if due to syphilis, whether inherited or acquired.

4. Hemorrhages into the vitreous in the young are of grave prognostic importance and point to the existence of general vascular degeneration.

5. In chronic interstitial nephritis and in diabetes retinal hemorrhages are of very grave prognostic significance, and independently of the presence of exudative retinitis point to a fatal termination of the disease. The mere presence of thrombosis of the central retinal vein with hemorrhages in the retina should arouse suspicion of the existence of albuminuria, and if this suspicion is confirmed by urinary analysis the prognosis in the case is more unfavorable than in those cases in which the hemorrhages do not exist."—*Medical Record*, February 3, 1900.

Some of the Recent Remedial Measures Which Have Come to Stay.—(Editorial in *Therapeutic Gazette*, Jan. 15, 1900). One of the newer therapeutic measures which offers considerable advantage in the treatment of grave and pressing complications is the hypodermic injection of sterilized salt solutions containing gelatin, for the purpose of arresting hemorrhages which cannot be stopped by means of direct application or compresses. This method, which is supposed to act by very materially increasing the coagulability of the blood, has been employed to such a large extent in France that it is there recognized as being a wise procedure, and in our own experience with it in this country it has given results which justify a continuance of its employment. It is hardly necessary to point out that these gelatin saline injections must be given under the strictest antiseptic precautions both in regard to the preparation of the skin of the patients, the solution itself, and the needle and syringe with which it is administered. The injections have apparently given good results in forming the clots in the aneurismal sacs, in arresting pulmonary hemorrhages, and in controlling other more constant but less active loss of blood. The injections commonly employed consist of eighteen grains of sodium chloride, in two ounces of distilled water, which should be administered with an antitoxin syringe, divided in two doses of one ounce each. When aneurism is to be treated by this method, an injection every day

or every other day is sufficient. In more pressing cases where the gelatin is to be used but for a short time, two injections may be given in the same twenty-four hours.

Another remedy which is surely obtaining a very definite therapeutic rank is taka-diastase, the ferment obtained by the process of Takamine, of Japan, and which is used for the treatment of those very common forms of dyspepsia arising from faulty digestion of the starches. There is no doubt whatever that this substance given in capsules alone or combined with some bitter substance like nux vomica, or some general tonic like arsenic, will often give an immense amount of relief.

Still another preparation of even more recent introduction is heroin, which is the diacetic acid-ester of morphin. This preparation has been introduced into medicine for the purpose of allaying cough, and is substituted for codein. It has a great advantage in that it is poisonous only when given in a dose which exceeds by one hundred times that dose which is therapeutically efficacious. It is supposed to produce sedation of the peripheral sensory nerves of the respiratory tract without depressing the respiratory center. Indeed it is claimed that under its influence the respiratory activity is increased rather than decreased, and therefore that under its use the same disadvantages do not arise as when morphin or codein is employed to allay cough. The dose, it will be remembered, is from one-sixth to one-third of a grain.

Still another remedy which has certainly come to stay is holocain, which finds its chief usefulness in ophthalmic surgery as a local anesthetic. It possesses certain advantages over cocain in that it does not cause mydriasis, and therefore does not tend to increase tension. It does not affect accommodation. It produces a greater degree of anesthesia of the iris than does cocain. It relieves severe and painful inflammation which resists cocain, and unless swallowed or injected subcutaneously does not produce poisoning. Finally and very important, it has no roughening influence on the cornea, and is strongly antiseptic in its action. On the other hand it does not tend to control hemorrhage as does cocain, since it does not cause primary contraction of the blood vessels. It may be employed in $\frac{1}{2}$ to 1 per cent. solution.

Still another drug which possesses very great usefulness is urotropin, a compound containing formaldehyd, which on being ab-

sorbed, is decomposed so that the formaldehyd is set free in the urine, exercising its powerful antiseptic influence. As a result it has proved itself of very great value in the treatment of cystitis associated with phosphatic and alkaline urine, not only exercising a useful, permanent influence, but often giving relief after a very few doses have been taken. It has also been found by Richardson to be a valuable drug for the purpose of preventing the spread of infection by typhoid fever germs, since it so disinfects the urine of typhoid patients that the bacillus of Eberth is destroyed. The dose of urotropin commonly employed is eight grains dissolved in half to one tumblerful of water, and taken three times a day.

Another drug is apocynum cannabinum, a medicinal plant to which considerable attention has been paid during the past year. A good fluid extract of this drug, in the dose of from one to five minims, twice, thrice, or four times a day, is capable of giving very great relief in cases of cardiac dropsy, both by its influence upon the heart and upon the kidneys. In overdoses it is apt to act as a violent purgative, and care should be taken that too great irritation of the gastro-intestinal tract is not produced by its use. Care should always be taken that the apocynum cannabinum is used, and that apocynum androsemifolium is not dispensed for it.

Preliminary Report of a Case of Acute General Septic Peritonitis Treated by Continuous Irrigation with Warm Normal Salt Solution.—In an article in which he details a case treated as described in the title of this note, Laplace reaches the following conclusions:

1. The peritoneal cavity stands with perfect safety a continuous irrigation with normal salt solution at a temperature of 100° during seventy-four hours.

2. In his case the infection of the peritoneum, which had been so violent and rapid, effectually ceased under this treatment. The symptoms—pain, vomiting and distension—ceased, and there was no constipation.

3. The patient stood the irrigation with comfort; not complaining of cold, for the warm water was so copious in its flow as not to have time to cool.

4. The copious irrigation, it is believed, dissolved and carried off the toxins as they formed; it reached the most dependent por-

tions of the peritoneal cavity, and removed infectious material; therefore, effectual drainage was established. It acted as a tonic to the heart. No doubt some of this solution was absorbed into the system. During three days the infection was held in abeyance by the antiseptic action of the salt, and phagocytosis had free scope to destroy the infectious bacteria permanently.

5. This method has not, to Dr. Laplace's knowledge, been used before. It had given benefit in an apparently hopeless case. The method is in accord with already well established surgical principles, and only novel in its application to the peritoneum. It may prove a valuable aid in the treatment of heretofore fatal cases of peritonitis, and Dr. Laplace trusts, therefore, that it may be worthy of further trial.—*Therapeutic Gazette*, Jan., 1900.

Taking Cold.—Dr. F. H. Bosworth, (*N. Y. Medical Journal*, Jan. 27, 1900) says: "It has always seemed to me that the expression 'taking cold' is susceptible of criticism. A cold in the head or an acute rhinitis, bears somewhat the same relation to 'taking cold' that the roseola of syphilis does to the disease in the blood, or that the eruption of scarlet fever does to scarlet fever. It is a great mistake to say that taking cold is a cold in the head. Acute rhinitis is simply the local manifestation of the general disturbance. We are protected from the dangers and menaces of the world by the outer coating of the body, viz., the skin, and when it ceases to protect us we become liable to colds. It is through the skin that we feel and contract colds. If we are not protected by the skin from low temperature we take cold. Why then are we not protected? The Lord sent us into this world with ample protection. We live in hot rooms and pile on clothing until the function of the skin is put to sleep, as it were. I long ago made up my mind that it was impossible to treat successfully these affections unless we taught our patients how properly to protect themselves from suffering from exposure in our great changes of temperature. This is only accomplished by teaching them those simple sanitary measures which protect them from taking cold and thus restoring to them what they have practically abolished. Those functions with which nature has endowed us tend to quit if we do not give them something to do. The best and practically the only protection against taking cold is a good vigorous, circulation—that is, a good capillary circulation

in the skin. We must give it exercise if we want it to do us good and if we do not give the skin exercise it quits. How do we put the skin to sleep? By simply piling on heavy clothing. We keep the skin in order by wearing thin clothes, suitable for the different changes in temperature. By putting on clothing we protect ourselves from suffering and the discomforts of low temperature, but thereby render ourselves exceedingly sensitive to exposure.

"There are two measures that are absolutely essential as aids to treatment in the management of so-called catarrhal cases, and what I mean by catarrhal cases are adenoids, rhinitis, etc. In the first place forbid all patients from wearing more clothing than is absolutely necessary. I recall a book, in which the author recommended patients to wear six suits of underwear during the year, changing them according to the rise and fall of the temperature. No teaching, it seems to me, could be more pernicious. One rarely changes his underwear without taking cold. We should get along with as little clothing and as few changes as possible. There are some rules I insist upon. One of them is to instruct my patients to wear but one suit of woollen underwear. Too much clothing not only renders the skin circulation sluggish, but hampers the great function of the skin—perspiration. Most of our woollen manufacturers in making up woollen underwear put the prickly side on the inside, and the dressed or smooth side on the outside, a feature exceedingly irritating to a sensitive skin. And so it is a good plan to tell such a patient to have his underwear made wrong side out. I would recommend one suit of underwear or a combination suit, if it is the right material, with short sleeves and low neck. The neck and arms are parts of the body that can be exposed with impunity. Furthermore the fabric should be as thin as is compatible with comfort.

"The next measure is the daily use of the cold bath. This beyond any other single measure promotes and stimulates a good circulation. The benefit of the cold bath is not only in its stimulation of the circulation, but also in its toning up of the nervous system. One word here as to the much vaunted Turkish bath. It would seem rather curious that we have to learn from the Turks how to bathe. Did any of you ever stop to think of the modus operandi of the Turkish bath? You go into a temperature say, of 185° F., and sweat and sweat. Now profuse perspiration is an abnormal

condition. I know of no earthly reason why we should sweat in this way. People say the object is to open the pores. The sweat pores, I suppose. These pores are always open; they are never closed. If you stop up the pores you are going to have a boil or an abscess. The Turkish bath is a luxury in which many indulge, but from a sanitary or hygienic point of view, I have always been skeptical as to its virtues."

Clinical and Pathologic Notes on Sympathetic Ophthalmia. Gifford (*Jour. Am. Med. Asso.*, Feb., 1900) reports several cases and calls attention to three points of importance: "The first is the entire absence of the premonitory symptoms, such as photophobia, ciliary injection and asthenopia, which most books still give as the warning of danger from sympathetic ophthalmia. None of these patients, nor any of the others whom I have seen with genuine sympathetic ophthalmia, had anything of the sort. The uninjured eye felt entirely well up to the time when the appearance of inflammatory products showed that the inflammation was there and, as the event proved, in such a way as to progress steadily in spite of prompt enucleation in most of them. The second point is the importance of daily test of vision, especially in cases which are not under the constant observation of an oculist, since in the cases in which the entire course of the disease could be watched, the failure of vision was the symptom which would first have attracted the attention of a non-expert. The third point is the value of large doses of salicylate of sodium after the disease has broken out. I had treated my other cases with atropin, hot applications and mercurial inunctions without any effect that I could determine, but the influence of the salicylate in these later cases was so marked and its result on the whole so favorable that I do not hesitate to recommend it as the most important remedy that I know for the disease. It should be noted, however, that the amount used was so large as possibly to be thought excessive by some; 180 grains in the twenty-four hours had to be given in Case two, before the disease was checked. This was given in fifteen grain doses in a teaspoonful of brandy, and the patient kept in bed while the salicylate was being taken. As the boy's weight was not over 130 pounds, a full-sized man would require at least 200 grains as a proportionate dose. Perhaps it is also worth mentioning that in Case two, and in one

which I have seen, heat applied in the ordinary way—i. e., moderate-sized pieces of cloth or cotton wet with hot water and changed every half minute—seemed to act unfavorably, while the greater body of heat furnished by poultices, changed frequently, seemed to do much more good. The explanation for this may be that in these cases much of the inflammation was seated so far back in the eye that the milder heat reached the deep-seated inflammation only in such a degree as to stimulate rather than check it. I have had a similar experience in deep-seated affections of the mastoid."

Some of the Causes of Failure to Relieve Asthenopia and Allied Symptoms.—Marlow (*Medical News*, Jan. 6, 1900) says that it is by no means a rare thing for the ophthalmologist to meet with people who express the greatest disappointment, surprise and sense of injury that a train of symptoms of years' duration, due perhaps to many complications, should not be relieved by the first glasses ordered.

Fifty years ago and less the matter of getting a pair of glasses was a much simpler affair than it is today, because at that period only the simpler errors were corrected. The subjects of asthenopia were advised long periods of rest, to adopt occupations not calling for close eye work, or were sent to the farm; while many doubtless became chronic neurasthenics.

Today the causes of asthenopia are better understood, although in many directions our knowledge of the true nature of hypermetropia, the demonstration of astigmatism as a common error of refraction, and the establishment of the importance of latent deviations of the visual axes, have greatly complicated the problem of fitting glasses, as well as widened the field of usefulness of the ophthalmologist.

If more people wear glasses than formerly, it is because the symptoms recognized to be due to eye strain have greatly increased in number, and because of the demonstration of the importance of small errors, formerly neglected. With the increase in the complexity of the ocular problems presented for solution and in the number of those seeking relief from symptoms, there are necessarily more primary failures to relieve than was formerly the case.

Patients seek the advice of one oculist, and if he fails to relieve them speedily, too often go to another. The second has to do the

same work all over again, and although he has the advantage of seeing the effect of the glasses prescribed by the first, is perhaps but little more successful.

The cases in which failure to relieve asthenopia occurs admit of fairly satisfactory classification on a clinical basis. They may be divided in the first place into two main classes: one consisting of curable cases, the other incurable cases.

The curable cases may be divided into three groups: 1. In which the failure is the fault of the patient. 2. In which it may be said to be the fault of the oculist. 3. In which it may be said to be the fault of the case, or more specifically, due to the extreme latency of some of the errors of refraction and equilibrium.

The incurable cases may be placed under two headings: 1. Congenital asthenopes—people whose eyes are incapable of a normal amount of work, independently of their refraction and muscular condition, and of the general health. 2. Cases in which the symptoms are due to organic disease of the eye or brain, or to some general disease.

Certain Effects of Benzoic Acid upon the Urine.—Ashhurst (*Philadelphia Medical Journal*, Feb. 24, 1900) thus sums up the evident effect on the urine of the exhibition of benzoic acid:

1. An inconstant diuretic action, accompanied by a slight diminution of the acidity of the urine.

2. A retardation or absolute prevention of the occurrence of the alkaline fermentation.

3. An action in nature germicidal or inhibitory to the growth of certain microörganisms either within the bladder or when introduced into the urine after voiding, these susceptible organisms, including especially those which tend to produce the alkaline fermentation, but which develop in the urine while it is still acid.

It should further be said that on several occasions while the benzoic was being administered to dogs, the urine was found to be filled with pus, highly alkaline and extremely ammoniacal. In each of these instances the condition was proved to be due to the discharging of a hypodermic abscess into the vessel in which the urine was collected. These samples were thrown out of the calculation. From this it appears that if an overwhelming quantity of septic material be present in or be introduced into the urine, even

the administration of benzoic acid will not prevent the urea from being broken up and the carbonate of ammonium from being formed. In this connection it may be said in regard to the therapeutic use of benzoic acid, that when there is a very large amount of residual urine, and a firmly established ammoniacal cystitis, the benzoic acid alone may be insufficient to render the urine acid, there being need as well to completely empty the bladder at sufficiently short intervals, so that the task of the benzoic acid, in coping with the bacteria, may not be rendered an impossible one by their overwhelming numbers and their entrenchment in a medium so copious and so strongly alkaline that no possible amount of normally acid urine can neutralize its alkalinity. As the alkalinity itself is a necessary condition to the development of most forms of bacteria, it is probable that in such a case, if the residual urine could but be kept acid for a few days, the bacteria that are immune to the effects of the benzoic acid could then maintain the acidity of the bladder-contents, by preventing the growth of such alkaline fermentative organisms as ordinarily would be liable to develop in the acid medium.

A Pathognomonic Sign (Koplik) of the Invasion of Measles. Ross (*Columbus Medical Journal*, Feb. 1900) says that in 1896, Koplik, of New York, in a paper published in the *Archives of Pediatrics*, described a sign he had observed for a period of ten years, and taught to students and physicians, which appeared on the mucous membrane of the cheeks and the inside of the lips, usually next to the teeth, and claimed this to be absolutely pathognomonic of beginning measles, occurring at some time in all cases. One of the most interesting features was that the eruption made its appearance usually from twenty-four to seventy-two hours before the eruption on the body, thereby making certain the diagnosis without, and previous to the appearance of the exanthem.

In describing the sign, the writer quotes from Koplik's paper in which he first describes the sign. He says: "If we look into the mouth at the time of the prodromal symptoms we see a redness of the fauces, perhaps, not in all cases, a few spots on the soft and hard palate. On the buccal mucous membrane we see invariably a distinct eruption. It consists of small, irregular spots of a bright red color. In the center of each spot there is noted,

in strong daylight, a minute, bluish-white speck. These red spots with the accompanying specks of a bluish-white color are absolutely pathognomonic of beginning of measles, and when seen can be relied upon as the forerunner of the skin exanthem."

From a study of fifteen consecutive cases occurring in Koplik's clinic the following conclusions are drawn:

1. That it is a most valuable sign, rendering possible an early diagnosis, previous to the appearance of the exanthem.

2. It is of great value in differential diagnosis. It is often impossible to differentiate true measles from rötheln, erythema and scarlet fever, and when measles complicate other diseases; also diseases which simulate measles in the early stages, such as lagrippe and simple colds.

3. It has been found to be a reliable sign, that when once seen has never failed, and is believed to be of great value in schools and hospitals and other institutions where children are congregated together.

Nasal Respiration.—Blake (*Columbus Medical Journal*, Feb. 1900) reviews entertainingly the subject of nasal respiration, its physiology and pathology, and emphasizes the following points:

1. Nasal respiration is the normal respiration.

2. A proper physical and mental development depends, in a large measure, upon free nasal respiration.

3. Nasal reflexes should command due consideration and attention.

4. Obstruction to nasal respiration is almost always adventitious, and not due to congenital conformation; hence an obvious pathologic cause should be sought.

5. Relief may often be afforded by the use of simple means, but more radical measures are amply justified when demanded.

BOOK REVIEWS.

Any medical book can be obtained through the Lancet at publisher's prices, postage free. Terms cash. The usual discounts are allowed.

A Textbook of Diseases of Women. By Charles B. Penrose, M. D., PH.D., Professor of Gynecology in the University of Pennsylvania; Surgeon to the Gynecean Hospital, Philadelphia. Illustrated. Third edition. Revised. Price, $3.50 net. Philadelphia: W. B. Saunders. 1900.

In less than three years this excellent book has passed through two editions, and the third is now before us. In this revised edition the book has been slightly enlarged, and every subject has been brought up to date. It is one of the best books on the diseases of women for the general practitioner and medical student. The illustrations are many, excellent and useful.

The International Textbook of Surgery. In two volumes. By American and British authors. Edited by J. Collins Warren, M.D., LL.D., Professor of Surgery Harvard Medical School, Boston; Surgeon to the Massachusetts General Hospital; and A. Pierce Gould, M.S., F.R.C.S., Eng. Lecturer on Practical Surgery and Teacher of Operative Surgery Middlesex Hospital Medical School; Surgeon to the Middlesex Hospital, London, England. Vol. I—General Surgery. Handsome octavo volume of 947 pages, with 458 beautiful illustrations in the text and 9 lithographic plates. Vol. II.—Special or Regional Surgery. Prices per volume: Cloth, $5.00 net; half morocco, $6.00 net. W. B. Saunders, Philadelphia.

The first volume of this superb work has been received. The art and science of surgery are advancing so rapidly there is certainly a place for another excellent book of reference. All that is known in the present day of surgical pathology, symptomatology and diagnosis is clearly stated, and the treatment given is a correct guide to modern practice. The editors have shown good choice in the selection of contributors. In the first volume we note the names of Chas. McBurney, E. H. Bradford, Geo. R. Fowler, M. H. Richardson, Bland Sutton, McLane Tiffany, L. G. Pilcher, Weller Van Hook, and others equally well known as teachers and leaders in surgery. All have performed their task well. Old methods have been omitted, and in the work we find only what is practical and useful in surgery of today. We predict that for some time it will be one of the leading reference and textbooks. The illustrations are many, clear and useful.

Recollections of a Rebel Surgeon (and other sketches); or In The Doctor's Sappy Days. By F. E. Daniel, M.D. Illustrated. 1899. Von Bœckman, Shutze & Co., Austin, Texas.

The author has long been known to the profession as a forceful and ready writer, and this book will add much to his reputation. It is a collection of sketches dealing more or less with the duties of the Confederate army surgeons. Through them run a story of short rations, short medical supplies, inadequate help, poor hospital facilities, and a large mortality. The sketches are more or less humorous, some very humorous, and these harrowing details crop out between the lines. Incidentally we must commend Dr. Daniel on producing a humorous medical book in which the humor is always within the bounds of decency, and for the most part, of refinement, characteristics

which other works of this class have failed to realize. The book is well printed, well bound (a "red back," of course) and poorly illustrated. We will prescribe it for "that tired feeling," blues and similar ailments, and feel sure it will act well.

The American Yearbook of Medicine and Surgery. Being a Yearly Digest of Scientific Progress and Authoritative Opinions in all Branches of Medicine and Surgery, drawn from Journals, Monographs and Textbooks of the leading American and Foreign Authors and Investigators, collected and arranged with critical editorial comments. In two volumes. Volume 1, Surgery; Volume 2, Medicine. By J. M. Baldy, M.D., Charles H. Burnett, M.D., J. Chalmers DaCosta, M.D., W. A. Newman Dorland, M.D., Virgil P. Gibney, M.D., C. A. Hamann, M.D., Howard F. Hansell, M.D., Barton Cooke Hirst, M.D., E. Fletcher Ingalls, M.D., W. W. Keen, M.D., Henry G. Ohls, M.D., Wendell Reber, M.D., J. Hilton Waterman, M.D., Samuel W. Abbott, M.D., Archibald Church, M.D., Louis A. Duhring, M.D., D. L. Edsall, M.D., Alfred Hand, Jr., M.D., Milton B. Hartzell, M.D., Reid Hunt, M.D., Wyatt Johnston, M.D., Walter Jones, M.D., David Reisman, M.D., Louis Starr, M.D., Alfred Stengel, M.D., A. A. Stevens, M.D., G. N. Stewart, M.D., Reynold W. Wilcox, M.D. Under the general editorial charge of Geo. M. Gould, M.D. W. B. Saunders, Philadelphia. 1900. Cloth, $3.00; half morocco, $3.75 per volume.

This yearbook has established such an excellent reputation for itself that we feel that in announcing its appearance we do all that is necessary. The list of compilers comprises names so well identified with progress in medicine and surgery that they are a guarantee of the completeness of the work. No one can fully cover in his reading all that is published during a year, and it is of inestimable value to have the literature reviewed by a body of men well qualified to cull that which is good and presented to us in Mr. Saunders' excellent style. A very commendable new feature of this yearbook is its division into two volumes. So many men are interested only in a certain branch of medical science that much of the material in a yearbook is of little value to them, and when put into one volume makes a somewhat unwieldy book. This is obviated by dividing the work into two volumes as above indicated, the two being sold for the old price of the one volume. We heartily recommend this book to all who wish to have in their library an epitome of the progress of medicine in 1899, the matter being carefully edited and critically reviewed by competent men.

Christian Science. An Exposition. By William A. Purrington, Lecturer in the University and Bellevue Hospital Medical College, and in the New York College of Dentistry upon Law in Relation to Medical Practice; One of the Authors of "A System of Legal Medicine." New York: E. B. Treat & Co, 241–243 West Twenty-Third Street. 1900. Price $1.00.

This book is composed of a number of papers which have appeared in the North American Review, New York Medical Record, New York Sun, and of several addresses delivered by the author of the book before certain medical societies. It comprises about 200 pages written in a lucid and clear style. It is intended to expose the dangerous teachings of Christian science, and contains as a frontispiece a photograph of a gangrenous foot of a child treated by a "healer." The author does not question the sincerity of the disciples of Mrs. Eddy, but denies their power to cure ailments. There is a copious index of droll absurdities of expression used by Christian Science's discoverer, Mrs. Eddy. The book is a splendid exposition of the fallacies of Eddyism and deserves a wide circulation in the hope that it may fulfill the purpose for which it was intended.

A Manual of the Practice of Medicine Prepared Especially for Students. By A. A. Stevens, A.M., M.D, Professor of Pathology in the Woman's Medical College of Pennsylvania; Lecturer on Terminology and Instructor in Physical Diagnosis in the University of Pennsylvania; Physician to the St. Agnes Hospital and to the Out-Patient Department of the Episcopal Hospital, etc. Fifth edition. Revised and enlarged. Illustrated. W. B. Saunders, Philadelphia. 1898.

Small books on medical subjects have a well-defined, though limited sphere. The subject of the Practice of Medicine is exceedingly well presented in this volume, and throughout can be seen the work of one familiar with teaching medical students, for whom the book is especially intended. The author will be pleasantly remembered by many who profited by his instruction, as students, and who, as practitioners, will find the matter concisely and accurately set forth. The presswork is very good, and the book is bound in flexible leather. We commend it as a handy book for refreshing the memory, and find nothing in it to criticise, but much to praise.

BOOKS AND PAMPHLETS RECEIVED.

The American Yearbook of Medicine and Surgery. Being a Yearly Digest of Scientific Progress and Authoritative Opinion in all Branches of Medicine and Surgery, drawn from Journals, Monographs and Textbooks of the Leading American and Foreign Authors and Investigators, collected and arranged with critical editorial comments. In two volumes. Volume 1, Surgery; Volume 2, Medicine. By J. M. Baldy, M.D., Chas. H. Burnett, M.D., J. Chalmers DaCosta, M.D., W. A. Newman Dorland, M.D., Virgil P. Gibney, M.D., C. A. Hamann, M.D., Howard F. Hansell, M.D., Barton Cooke Hirst, M.D., E. Fletcher Ingals, M.D., W. W. Keen, M.D., Henry G. Ohls, M.D., Wendell Reber, M.D., J. Hilton Waterman, M.D. Samuel W. Abbott, M.D., Archibald Church, M.D., Louis A. Duhring, M.D., D. L. Edsall, M.D., Alfred Hand, Jr., M.D., Milton B. Hartzell, M.D., Reid Hunt, M.D., Wyatt Johnson, M.D., Walter Jones, M.D., David Reisman, M.D., Louis Starr, M.D., Alfred Stengel, M.D., A. A. Stevens, M.D., G. N. Stewart, M.D., Reynold W. Wilcox, M.D. Under the general editorial charge of Geo. M. Gould, M.D. W. B. Saunders, Philadelphia. 1900. Cloth, $3.00; half morocco, $3.75 per volume.

Christian Science. An Exposition of Mrs. Eddy's Wonderful Discovery, including its Legal Aspects. A Plea for Children and other Helpless Sick. By William A. Purrington, Lecturer in the University and Bellevue Hospital Medical College, and in the New York College of Dentistry upon Law in Relation to Medical Prac-

tice; one of the authors of "A System of Legal Medicine." New York: E. B. Treat & Co. 1900.

A Manual of the Practice of Medicine. Prepared Especially for Students. By A. A. Stevens, M.D., Professor of Pathology in the Woman's College of Pennsylvania; Lecturer on Terminology and Instructor in Physical Diagnosis in the University of Pennsylvania; Physician to St. Agnes' Hospital and to the Out-Patient Department of the Episcopal Hospital, etc. Fifth Edition. Revised and enlarged. Illustrated. Philadelphia: W. B. Saunders. 1898.

A Textbook of Diseases of Women. By Charles B. Penrose, M.D., PH.D., Professsor of Gynecology in the University of Pennsylvania; Surgeon to the Gynecean Hospital, Philadelphia. Illustrated. Third edition. Revised. Philadelphia: W. B. Saunders. 1900.

Recollections of a Rebel Surgeon (and other sketches); or In The Doctor's Sappy Days. By F. E. Daniel, M.D. Illustrated. 1899. Von Boeckman, Schutze & Co., Austin, Texas. Price $1.00.

Obstipation. A Practical Monograph on the Disorders and Diseases of the Rectal Valve. By Thomas Charles Martin, PH. M.D., of Cleveland, Ohio; Fellow of the American Proctologic Society; Professor of Proctology in the Cleveland College of Physicians and Surgeons: Proctologist to the Cleveland General Hospital, etc. (Reprinted from the August number of the *Philadelphia Monthly Medical Journal.*) The Philadelphia Medical Publishing Co. 1899.

Metastatic Uveitis in Both Eyes, Causing Blindness, Resulting from an Intense Inflammation of the Nose and its Accessory Sinuses. By William Campbell Posey, M.D., Philadelphia. (Reprinted from the *New York Medical Journal*, January 22, 1898.)

A Clinical Study of Two Hundred and Eighty-Seven Cases of Hyperphoria. By Wm. Campbell Posey, M.D., Philadelphia. (Reprinted from the *Philadelphia Medical Journal*, April 8, 1899.)

Report of One Hundred Consecutive Cases of Cataract Extraction. By Sam'l Theobald, M.D., Baltimore, Md. (Reprinted from *American Journal of Ophthalmology*, December, 1899.)

Akromegaly: With Report of a Case Presenting Some Unusual Features. Height of Patient, Eight Feet and Six Inches. By Wm. Nicholas Lackey, M.D., of Gallatin, Tenn. (Reprinted from the *Philadelphia Medical Journal*, July 22, 1899.)

Why Some Severe Cases of Appendicitis End in Recovery Without Operation. By J. H. Carstens, M.D., Detroit. (Reprinted from the *New York Medical Journal* for August 12, 1899.)

Pulmonary Tuberculosis. Report of Cases Treated with Intrapleural Injection of Nitrogen, with a Consideration of the Pathology of Compression of a Tuberculous Lung. By A. F. Lemke, M.D., Chicago. (Reprinted from the *Journal of the American Medical Association*, October 14, 21, 28, 1899.)

A Contribution to the Etiology of Pompholyx. By Martin F. Engman, M.D. (Reprinted from the *Medical Review*, November 11, 1899.)

Prognosis of Laryngeal Tuberculosis. By Robert Levy, M.D., Denver, Col. (Reprinted from the *Journal of the American Medical Association*, September 16, 1899.)

Sinus-Thrombosis; Cure Without Opening the Sinus. By Robert Levy, M.D., Denver, Col. (Reprinted from the *Laryngoscope*, St. Louis, August, 1899.)

Lessons from Two Hundred and Twenty-Four Consecutive Abdominal Sections. By. J. H. Carstens, M.D., Detroit, Mich. (Reprinted from the *American Journal of Obstetrics and Diseases of Women and Children*, vol. 29, no. 5, 1899.)

The Municipal Control of Prostitution in the United States. Some Opinions as to the Methods Adapted to Municipal Care and Control of Prostitution and Venereal Diseases. By Isadore Dyer, PH. B. (Yale) M.D. (Reprinted from the *New Orleans Medical and Surgical Journal.*)

Some Practical Remarks on the Anatomy of the Temporal Bone, with Demonstrations. By Emil Amberg, M.D., Detroit, Mich. (Reprinted from November number, 1899, *Physician and Surgeon*, Detroit and Ann Arbor.)

Meatus with Abnormal Direction. By Emil Amberg, M.D., Detroit, Mich. (Reprinted from the *Physician and Surgeon*, Detroit.)

Demonstration of Some New Ear Instruments. Emil Amberg, M.D., Detroit, Mich. (Read before Michigan State Medical Society at Kalamazoo, May 4 and 5.)

A New Ear Syringe. By Emil Amberg, M.D., Detroit, Mich. (Reprinted from the *Medical Record*, May 27, 1899.)

Ear Complications of Influenza. By Emil Amberg, Detroit.

New Laboratory Apparatus. (Reprinted from the *Journal of Applied Microscopy*, vol. 2, no. 10.)

The Medical Treatment of Movable Kidney. By Alfred Stengel, M.D., Philadelphia. (Reprinted from the *University Medical Magazine*, September, 1899.)

Gastroptosis: Report of a Case in Which a New Operation was Undertaken and the Patient Greatly Improved. By Alfred Stengel, M.D., and Henry D. Beyea, M.D., of Philadelphia. (Reprinted from the *American Journal of Medical Sciences*, June, 1899.)

The Propagation of Diseases by Means of Insects, with Special Consideration of the Common Domestic Types. Address in Hygiene. Delivered before the Pennsylvania Medical Society, at its Annual Meeting, Johnstown, Pa., Wednesday, May 17, 1899. By W. M. L. Coplin, M.D. (Reprinted from the *Philadelphia Medical Journal*, June 10, 1899.)

A Case of Diabetes Mellitus Quickly Following Mumps. On the Pathological Alterations of the Salivary Glands, Closely Resembling Those Found in the Pancreas in a Case of Diabetes Mellitus. By H. F. Harris, M.D. (Reprinted from the *Boston Medical and Surgical Journal* of May, 18, 1899.)

Clinical Notes from the Gynecological Service of the Howard Hospital. By Barton Cooke Hirst, M.D., Philadelphia. (Reprinted from the *University Medical Magazine*, November, 1899.)

Acute Inflammation of the Middle Ear, Complicating Scarlet Fever and Measles. By Charles H. May, M.D., of New York. (Reprinted from "*Archives of Pediatrics*," July 1899.)

NEWS AND NOTES.

Mr. W. C. Davis has been re-elected superintendent of the city hospital.

Dr. T. E. Edwards has gone to Mexico and will be absent about three months.

Dr. Wirt Johnson, a well-known practitioner of Jackson, Miss., died last month.

The Central Tennessee College, of Nashville, graduate a medical class of thirty-eight on February 21.

Dr. Lauder Brunton, the well-known English physiologist, and formerly in charge of the celebrated Hyderabad Chloroform Commission, has been knighted.

The Lancet extends its sympathy to Dr. R. W. Barton, of Marion, Ark., in the loss of his wife, and to Dr. L. A Drouillard, of this city, whose mother recently died.

Dr. Ernest V. Sangree, professor of bacteriology and pathology in the University of Illinois, died on February 23, of meningitis. He was formerly connected with Vanderbilt University, Nashville.

Dr. Lewellys F. Barker, associate professor of anatomy and assistant pathologist of Johns Hopkins Hospital, Baltimore, has accepted the professorship of anatomy in the University of Chicago and Rusk Medical College.

The City Council has reduced the number of physicians on the staff of the city hospital by two physicians and two surgeons. This makes the size of the staff in these departments as originally provided for—four physicians and four surgeons.

The following changes have been made in the staff of St. Joseph's Hospital: Dr. W. B. Rogers retires from the position of visiting surgeon and is appointed consulting surgeon. Dr. F. D. Smythe is appointed visiting surgeon and Dr. E. E. Haynes visiting gynecologist.

The annual meeting of the Tennessee State Medical Society will be held in Knoxville on April 10, 11 and 12. Dr. D. E. Nelson, of Chattanooga, is President; Dr. W. D. Haggard, Jr., of Nashville, Secretary, and Dr. S. R. Miller, of Knoxville, chairman of the committee on arrangements.

The Illustrated London News publishes pictures of Dr. W. Watson Cheyne and Sir Wm. Thomson, both of whom have gone to South Africa for duty with the British troops. Mr. Treves, Dr. Conan Doyle and others are also at the front professionally, the latter having the charge of an ambulance corps.

The report has been circulated that the New Orleans Polyclinic has been suspended on account of smallpox in New Orleans. This statement is absolutely false. The Polyclinic has had a continuous course since November 20, and will continue until May 12. The smallpox situation in New Orleans has at no time justified any apprehension on the part of students attending the Polyclinic or on the part of those who might wish to do so.

At the request of the French Society of Electrotherapy and Radiology, the International Congress of Medical Electrology and

Radiology is connected to the International Congress of 1900. This Congress will take place in Paris, from the 27th of July to the 1st of August, 1900. All inquiries for further information must be forwarded to Prof. E. Doumer, General Secretary, 57 Rue Nicholas-Leblanc, Lille.

The Wayne County (Mich.) Medical Society is agitating the subject of obtaining uniform requirements and reciprocity in the matter of licenses among the different State medical examining boards. From their committee's report, we learn that replies have been received from fifty boards, forty-two being favorable, three unfavorable and five undecided. Of course uniform requirements must first be obtained. We are much in favor of the plan but fear it will be long in maturing, though such an agreement between a few States might be made as a beginning.

The following ordinance explains itself:

Be it ordained by the Legislative Council of the City of Memphis, That hereafter it shall be a misdemeanor for any person to spit on any sidewalk within the limits of the City of Memphis, or upon the walks in any public square in said city, or upon the floor or platform of any street car operating within the city limits, or upon the platforms of railroad stations, or upon the floor of any railroad passenger stations within the city.

Any person violating this ordinance shall be fined not less than $2 nor more than $25 for each and every offense.

Passed third and final reading February 28, 1900.

Attest: W. B. Armour, Secy. J. J. Williams, Mayor.

The Twenty-fifth Annual Meeting of the American Academy of Medicine will be held at "The Shelburne" on the beach at the end of Michigan avenue, Atlantic City, N. J., on Saturday, June 2d and Monday, June 4th, 1900.

The following papers are promised, and titles given are subject to revision.

1. President's Address. Dr. G. Hudson Makuen, Philadelphia.

Contributions to the Annual Symposium—"The Medical Aspects of the Home."

2. "What are the Essential Conditions for a Habitation to Develop and Maintain a Healthful Family Existence?" Dr. Rosa Engelmann, Chicago.
3. "The Influence of Early Training of Manly and Womanly Qualities to Avoid Degeneracy." Dr. J. Cheston Morris, Philadelphia.
4. "Artificial Lighting of the Home." S. D. Risley, Philadelphia.
5. "The Influence of Medical Supervision of Children in their Homes." Dr. J. Madison Taylor, Philadelphia.
6. "The Physician's Influence *in re* Vacation Schools." Dr. Helen C. Putnam, Providence.

7. "Defectives and Delinquents Inside and Outside the Family Circle." Dr. James W. Walk, Philadelphia.

Papers on miscellaneous topics:

8. "Is Coöperation Between Colleges of Arts and Sciences and Schools of Medicine Desirable?" Dr. A. L. Benedict, Buffalo.
9. "Physiologic Psychology as a Necessary Element in Medicine." Dr. W. J. Herdman, Ann Arbor.
10. "Medical Education of Today." Dr. Bayard Holmes, Chicago.
11. "Neglected Clinical Opportunities in American Medical Centers." Dr. S. A. Knopf, New York.
12. Subject to be announced. Dr. W. L. Pyle, Philadelphia.
13. "The Physician vs. Medical Proprietors and Medical Patentees." Dr. A. Ravogli, Cincinnati.
14. "Medicine in the Philippines." Dr. Harry Park Ritchie, St. Paul, recently on medical duty with the U. S. V. in Luzon.
15. Report of Special Committee to formulate the conclusion reached regarding Specialism and Advertising at the last meeting of the Academy.

THE LEPER.—

Unfavored of God's kind,
And set apart, a curse;
A living death for men to pity,
As they shudder at the worse
Than sin, or pain, or shame
Of *It;* for can a name
Be borne by one of these?

Not spotted white, nor snowy clean,
As Bible tales remark it;
But, bursting through a boiling skin
Of lumps and bumps, a thickened mass
Of bronzed and blackened human kin.
With here and there a spot of brown
Or lighter hue, while over all a tint of red
By Nature's thrown, as if to hide the frown
Which masks the soul of those
Who bear the burden of the blight.

Nor king nor serf the scourge hath spared,
And as the ages into æons run,
These sightless, voiceless human parodies
Will breathe the tones of the Unblest,
Accursed by all, marked by Fate
As victims of the great Unrest,
The Morbid in the True, too late
To save their souls for better things.
And so the fell decree makes members
One by one to fall, until at last
The end finds semblance only of a past,
A trace alone of kinship to the race
Which bore it, in this, a mass
Of tissues, human once, but now
Distorted, framed and bound in shapes
Fantastic in their frightful symmetry,
And shorn of everything but form.—*Isadore Dyer, M.D.*

N. O. Med. & Sur. Jour., March, 1900.

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Mercurol is particularly destructive to pyogenic organisms. It exerts a selective antagonistic action upon the Gonococcus, whether found in the urethral crypts or in the conjunctival sac. In urethritis and vaginitis of specific origin, as an antiseptic dressing in abscesses, to control suppurative conditions, and in fact wherever pus-forming bacteria exist, there Mercurol is indicated. It is neither caustic, corrosive, nor irritating.

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In ounce vials, per oz., $1.75
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Ulcers and Burns (use 5% Ointment).

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CLINICAL NOTES.

The steamships *City of Rome* and *State of Nebraska* have been chartered to leave New York on June 30, 1900, especially for physicians, their families and friends who desire to visit the Paris Exposition and other parts of Europe. Trip to last thirty-two days. Rates low and first-class passage. The physicians of the West are going in a body, and the physicians of Alabama, Mississippi, Louisiana, Arkansas, Tennessee and Indian Territory have been invited to go with them.

For full particulars, address G. G. Buford, M.D., Memphis, Tenn.

Make a Note of This.—It is a matter of common observation that many cases of bronchitis will persist in spite of continued, varied and judicious use of expectorants. "The cough," says one prominent physician, "hangs on, harasses the patient with its frequency and severity, and is exceedingly liable to recur every winter, to become a regular 'winter cough,' with its sequelæ of emphysema, asthma and, ultimately dilatation of the right heart."

Dr. Milner Fothergill, of London, insisted that cough of this character is due to lack of tone, not only in the general system but in the blood vessels of the bronchioles. This authority demonstrated that the only successful method of treating this form of cough is by means of appropriate systemic and vascular tonic medication. It is particularly in this class of cases that Gray's Glycerine Tonic Comp. has gained a most enviable reputation. This remedy, while a most palatable and agreeable one, not only has a selective tonic and antiphlogistic action upon the respiratory mucous membrane, but it removes the ever-present element of systemic depression. The beneficial effects of Gray's Glycerine Tonic Comp. even in rebellious cases are invariable and most pronounced.

Sanmetto as an Internal Remedy for Genito-Urinary Conditions.—While fully realizing the superfluity of further testimonials concerning a remedy so well and favorably known to the entire medical profession as is Sanmetto, yet as I possess an extended knowledge of its reliability based on several years clinical experience and on the treatment of hundreds of cases in which it has proven itself eminently fitted to lighten the cares of the genito-urinary surgeon, I am perhaps invested with a certain authority which should permit me the privilege of adding my meed of praise. In all the inflammatory conditions of the genito-urinary tract, from the meatus to the pelvis of the kidney, the administration of Sanmetto is invariably beneficial. It not only renders the urine bland and unirritating, but also exerts a specific action on the inflamed tissues, soothing and restoring the tonicity of the parts. Its tonic action on the prostate is of such a nature that it proves of equal advantage

Trophonine

a palatable and nutritious liquid food, contains the nutritive elements of beef, egg albumen and wheat gluten, so prepared as to be readily absorbed and aid almost immediately in the process of reconstruction. It furnishes the sick with the largest possible supply of nourishment and with the minimum tax on the digestive organs.

Protonuclein

by increasing the number of Leucocytes, destroys toxic germs, increases the inherent resistance to disease, quickens glandular activity, arouses the nutritive forces, gives tone to the system, and stimulates cell-life throughout the organism.

Peptenzyme

is the only perfect digestive. It digests every variety of food. In physiological activity it presents the active and mother ferments of the entire group of digestive organs. It aids digestion by furnishing an additional supply of protoplasmic material out of which active ferments are elaborated, and perfects the process by increasing cellular activity.

Samples and literature on request.

Reed & Carnrick, - - New York.

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in cases of either hyperplasia or of atrophy, and there is no remedy so uniformly successful in the treatment of atonic impotency or pre-senility. I have found it of inestimable service in the preliminary preparation of cases requiring surgical interference, and, combined with salol, use it constantly to secure urinary antisepsis. I am fully of the opinion that Sanmetto represents all that could be hoped for or desired as an internal remedy for genito-urinary conditions. H. R. Weber, M.D., Univ. Md. School of Medicine, 1886, Member Am. Med. Assn. etc., Chicago, Ill.

Acute Rheumatism.—Dr. G. C. H. Meier, (*American Therapist*, December, 1899) states that his experience with the salicylates during the past twenty years has convinced him of the difficulty of administering them in many cases; even if given in capsules or wafers many patients object to salicylate of sodium on account of the resulting disturbances of the stomach, as evidenced by nausea, distress in the epigastrium, and even vomiting. Occasionally, he has also witnessed headache, tinnitus and vertigo during its use. These disadvantages of salicylates have led him to experiment with aspirin, a new combination of salicylic acid and acetyl, which passes unchanged through the stomach, and is not decomposed until it reaches the intestinal canal, thus avoiding any action upon the stomach. He has given aspirin in the same dose as salicylate of

sodium, and owing to its insolubility has generally placed the desired dose upon a tablespoon, adding some sugar and water. From his experience with aspirin up to date, he considers himself able to assert that its effect differs in no wise from that of salicylate of sodium, and that it has the great advantage of being entirely devoid of troublesome effects upon the stomach. This is well illustrated by the twelve cases which are reported in full in his contribution.

Diet in Typhoid Fevers.—Fred C. Schurtleff, M.D., Los Angeles, Cal., says; Much has been written both pro and con in reference to this or that article of diet in the management of typhoid fever. It is a settled fact that the food must be fluid, highly nutritious and easy of digestion, for the maintenance of nutrition is imperative in wasting disease. Milk is probably the most extensively used, and will form the main article of diet so long as fever lasts. I have used milk in nearly all its various forms in the care of my cases from frozen or boiled sweet milk to buttermilk, from sweet milk, milk with lime water to that partially digested with pepsin or pancreatin when digestion was enfeebled. The tendency in milk diet is to overfeed by forcing too large quantities at one feeding and thereby cause a disgust for that diet upon which we have pinned our faith. If one insists upon an absolute milk diet, not infrequently you will find your patient has gone without it rather than take it. They fret under its administration, digestion is interfered with,

WE APPRECIATE THE CONFIDENCE placed in us by the medical profession and public, and we assure both that we guard it zealously. Our every effort is to deserve more and more the continued good faith and patronage of both. Our past success is due entirely to our painstaking and careful service, combined with the use of the BEST goods obtainable. On this basis we shall continue to do business.

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curds swarming with bacteria of decomposition are found in the increased diarrheal discharges, plus the bacteria of typhoid fever already existing, hence the object which we wish to attain so far as it is possible, (that of rendering the gastro-intestinal tract aseptic) is defeated from the outset by error in diet. I have often been puzzled as to what to substitute for milk in this class of cases until the stomach became more tolerant. I have tried various farinaceous substances and have discarded them on account of the increase of flatulency they almost invariably produce.

For some time past I have tided my patients over their critical period by tablespoonful doses of liquid peptonoids every two hours, giving nothing else in the way of nourishment but the above remedy. I cannot speak too highly of this elegant preparation where digestion is below par, as a highly nutritious food that will not curdle upon the stomach or leave a residue in the intestinal tract. It is a slightly stimulating food, consequently your cases as a rule will require less alcoholic stimulants, a great desideratum in some cases. I do frequently carry through my cases of typhoid successfully, where no other article of diet is given from the time I make the diagnosis until convalescence is firmly established and I call the attention of the profession to it for that class of cases in which milk cannot be taken.—*Southern California Practitioner.*

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Nothwithstanding the large number of Hypophosphites on the market, it is quite difficult to obtain a uniform and reliable syrup. "Robinson's" is a highly elegant preparation, and possesses an advantage over some others, in that it holds the various salts, including iron, quinin, strychnin, etc., in perfect solution, and is not liable to the formation of fungous growths.

THE NEW ORLEANS POLYCLINIC.—*Thirteenth Annual Session* opens November 20, 1899—closes May 10, 1900. Every inducement in clinical facilities for those attending. The specialties are fully taught. Further information, New Orleans Polyclinic, New Orleans, Louisiana.

The Laboratory of the Board of Health.

Exchange and Front Streets, Memphis, Tenn.

To the Medical Profession:

The Board of Health makes the following examinations free for the city Physicians: Exudate and sputum for diphtheria and tubercle bacilli, typhoid and yellow fever blood reaction and malaria organisms. well and cistern water and milk.

For other work I will charge the following fees: Urinalysis, chemical and microscopical, $2.00; including staining for tubercle bacilli, $3.50. Quantitative for sugar, $2.50. This covers the work necessary to make a conscientious diagnosis, and for *life insurance*. Pus for gonococci and other microörganisms, $2.00. Feces for parasites, eggs, etc., $5.00. Blood for typhoid and yellow fever reaction, for malaria organisms, diphtheria exudate and sputum for tubercle bacilli, $2.00. Other examinations for poisons, etc., according to labor and material consumed.

FELIX PAQUIN, Ph. B.,

Chemist and Bacteriologist of the Board of Health.
Member of the Association of Official Agricultural Chemists.

THE

MEMPHIS LANCET.

VOLUME IV. APRIL, 1900. No. 4

ORIGINAL ARTICLES.

CASE OF ADVANCED EXTRA-UTERINE PREGNANCY. OPERATION SEVEN WEEKS AFTER COMPLETION OF TERM.

BY R. B. MAURY, M.D.
MEMPHIS.

The case which I here report is one of extra-uterine pregnancy occurring in a multiparous woman after eight years of sterility.

Early in the pregnancy there were the usual symptoms of tubal rupture, beginning six or seven weeks after conception with a bloody discharge like menstruation; then sudden seizure while on the street, with excruciating abdominal and pelvic pain followed by symptoms of collapse, requiring the hypodermic use of morphine for relief. The fetus survived the rupture and lived on to full term. The real nature of the case was not recognized by those in charge. Five weeks afterward the patient came under my charge, and two weeks later the operation was perform.

Mrs. ——, 40 years old, having been married 19 years, was admitted for treatment October 22, 1899. Her sixth and last labor occurred in 1891. She gave a history of pelvic inflammation three years after the birth of the child. After a time her health was restored.

The last menstruation occurred November 10, 1898. On the 19th of December following, a bloody discharge appeared and continued to December 28. On that date while on the street, she was seized with severe abdominal pain, became pulseless and covered with a clammy sweat, and had to be carried upstairs to her room. Restoratives

were used and the bloody discharge ceased, but returned in forty-eight hours and lasted eight or nine days to January 7, 1899. She suffered paroxysms of pain for three days after this seizure occurred. No membrane was passed so far as she knew. She noticed during the first week in March that she was getting large. Previously weak and thin, she was now gaining flesh. At times she had cramps in the left side of the abdomen. Quickening occurred on the 22d of March. She never felt a child move so actively as this one did, but she was convinced that it was not in the right place. The breasts enlarged, and latter part of August became very tense, and there was very much colostrum in them. She expected her confinement about 20th of August. At this time she began to have slight pains in the womb and sides. She engaged a nurse and prepared for her confinement. September 5th she had pains all night and the child moved incessantly. September 12th pains returned and the child's movements were as active as ever. September 16th the movements were very vigorous. On September 17th the movements became feeble. After this they were felt no more. Those around her recognized the death of the child, but did not understand the true nature of the case. Since then the abdomen has become smaller, and the breasts have become flabby, though there is still milk in them. This brings the history to the 22d of October, when she came to me. Examination of this patient revealed a large abdominal tumor quite symmetrical in shape reaching nearly to the epigastrium. It was of elastic feel and without fluctuation, and did not present any of the bony prominences or outlines of a child. The physical examination furnished no grounds for suspecting the presence of a child. Examination through the vagina did not reveal anything which could throw light on the nature of the tumor, except that the uterus was felt close to it on the right and in front, and the *uterine cervix was open so as to admit the index finger to the internal os*. The uterine depth was nearly four inches.

I felt no doubt that the case was an extra-uterine gestation, with the placenta spread out and attached to the front wall of the fruit sac. It is interesting to note that there had been no occurrence of a "show" or bloody discharge at the time of the false labor. Indeed no time could be fixed when the false labor occurred, for the patient had pains at intervals from 20th of August to the 17th of September. Pains associated with the movements of the child up to the time of its death. Both Parry and Tait attached great importance to the occurrence of this "show" as a diagnostic sign of great value, and Mr. Tait says that after having almost exhausted the literature of the subject he is satisfied that the occurrence of the "show" is invaluable in the extra-uterine gestation which has reached full term. This patient states that she had none. Operation for removal was delayed two weeks because the placenta was implanted in front, and must be detached before delivery of the child. It was thought desirable to delay until the placental circulation had lost much of its activity.

Before coming here the patient had had rigors and sharp fevers. These occurred daily after she came to me, and she suffered no little from too frequent movement of the bowels, accompanied with pain extending to the left hip and thigh, and with much rectal tenesmus. The bowel disturbance and the tenesmus I ascribed to the attachment of the placenta in part over the sigmoid flexure.

The operation was done November 7. The incision through the median line revealed a tumor with slight adhesions to the abdominal wall. The tumor had a peritoneal covering. On dividing the sac wall the placenta came into view. It was detached with the fingers first to right and then to the left of the median incision, but I would not get beyond its lateral margins so as to reach the fetus. On detaching it

upward in the direction of the navel its margin was reached and the fetus delivered. The child was very large, weighing over ten pounds. As the circulation in the placenta was still active and the bleeding free, I did not disturb it (the placenta) further. The cord was brought outside and cut.

The incision in the sac wall was closed by suture, except about two inches at the lower end. The abdominal wall incision was closed with through-and-through silk-wormgut sutures to the same distance, and several of these were made to include the sac. The opening in the sac was then stitched to the opening in the abdominal wall. A gauze drain was carried through this opening to the bottom of the fruit sac. After operation the symptoms were favorable and convalescence was soon assured.

The drainage arrangements were not distubed for a week. Then the discharge was offensive. The drains were removed; the sac was washed with peroxide of hydrogen and afterward with warm salt solution. The index finger was used to detach more of the placenta. Here and there strong rootlets from it were felt running into the sac wall. Force was not used to separate them. No attempt was yet made to remove placenta. On 21st of November, two weeks after operation, quite a large portion of placenta was removed by forceps guided by the finger. Previous to this the stitches had all been removed, and the wound healed without suppuration. Every second day the sac was cleansed and fresh gauze drain placed in it. On November 25 another large piece of placenta and a portion of the amnion were removed with little bleeding. Rootlets were still felt in places and I did not tear them. The sac had shrunken much and the placenta came within reach more easily.

The discharge was quite offensive and deodorants were used on the dressings. The patient continued to do well. There was a very moderate rise of temperature in the evenings, but she was steadily improving in strength, had a good appetite and slept well.

On December 3 all the remaining portions of placenta and amnion were removed and after this the discharge was quite free from odor. She improved very rapidly in every way, and was out of bed on December 20. The sac was now very small. It was injected every other day with iodoform and glycerin. Its capacity on January 1 was no more than two drachms. The uterus was now small. Involution seemed complete. The patient was discharged with a small sinus and has continued to do well since.

It may be remarked that this way of dealing with cases of advanced extra-uterine pregnancy up to and beyond nine months, will probably give the best results. Open the sac, deliver the child, and do not disturb the placenta at the time of operation.

This is my fourth case of advanced extra-uterine gestation. In the first case the fetus had been dead six months. The placenta was in front, but was non-vascular and was removed at the time of operation. The sac was stitched to the abdominal wall and drained. The patient died one month later of pulmonary tuberculosis, having cavities in both lungs.

The second and third cases were advanced respectively to three and four months beyond term. I yielded to the surgical tempta-

tion to do the ideal operation of removing the sac and placenta. In one case the patient lived only a few hours, dying of shock. In the other, bronchitis occurred on the sixth day and death on the thirteenth day. She was septic.

111 Court Street.

WHY I USE PEPTO-MANGAN "GUDE."
AN EXPERIMENTAL DEMONSTRATION.*

BY WM. KRAUSS, PH.G., M.D.
MEMPHIS.
Director of the Microscopic Laboratories, Memphis Medical College, Pathologist and Visiting Physician to St. Joseph's Hospital, etc., etc.

Some five years ago I wrote a paper for the *Memphis Medical Monthly*, giving a résumé of the evolution of the iron compounds, and appended a report of cases giving blood counts, etc. The manufacturers of the preparation I preferred saw fit to reproduce the case reports in their pamphlets, but said nothing about the reasons that induced me to prefer their product.

At a recent joint meeting of physicians and pharmacists I was criticised for opposing the use of readymade compounds, while still advocating the use of Pepto-Mangan "Gude," which is a proprietary preparation. I hesitated considerably about bringing the matter up again, because I dislike to build up a reputation as an endorser, and have never in any other instance written an article endorsing a proprietary preparation.

I hope, however, to show you this evening that there is no pharmacopeial preparation that meets the requirements of an ideal iron compound, and, until this is found, I intend to continue to use what has never disappointed me, and is not based upon mere faith. The work of Bunge is too well known to be now quoted, and I will only make a few experiments before you this evening and show the reasons for the faith that is in me. There may be other proprietary iron compounds, and doubtless there are, that will come up to the same requirements, but I see no advantage in swapping the devil for the witch.

It is not necessary to repeat all the tests with all the official iron preparations, because they are divisible into groups, all the salts of

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* Read before the Memphis Medical Society.

one group behaving very much alike toward the gastric and intestinal juices.

An ingenious theory recently put forward regarding the action of the mineral salts of iron is, that they decompose the substances in the intestinal tract which precipitate the *food iron* so that it may be absorbed. This is the only rational explanation of the fact that we do occasionally get results from them. On the other hand, it is far more rational to use an iron compound that can be, and is absorbed, for then we are reckoning with known quantities, instead of blundering along, giving more iron at a dose than is contained in the entire body, and incidentally deranging the digestive functions by precipitating the gastric, pancreatic and intestinal juices, and producing constipation by reason of the very astringent nature of some of the iron salts.

Beginning with the organic double salts, of which the scale salts are representatives, we notice upon the addition of this gastric juice, that a precipitate is formed; the double salt is decomposed and ferric salt remains, which is insoluble, both in gastric and intestinal juice.

The tincture of ferric chlorid will precipitate some of the gastric constituents, though most of the iron will remain in solution in the hydrochloric acid; the iron still in solution will not be absorbed, because its non-diffusibility is taken advantage of in the manufacture of *dialised iron*, the acid passing through the animal membrane; when the iron finally reaches the intestine, the alkalin carbonates promptly precipitate it. Ferrous sulfate behaves similarly. In both instances, as you see, the very insoluble ferric oxid is finally formed. If you have ever tried to remove iron stains from your water pitcher, you have some idea how insoluble it is.

The insoluble compounds, like reduced iron, or Vallet's mass, only serve to render inert the arsenic with which they are usually prescribed; if dissolved at all in the stomach, they are re-precipitated in the intestine.

Taking now Gude's preparation, we find it soluble, not only in all these reagents, but also in a mixture of them. Potassium ferrocyanid readily gives the iron reaction, excess of ammonia will separate it, redissolving the manganese, which is then recognized by the color of its sulfid; the alkalin copper solution gives the reaction for pepton, showing that it is what the label says. It mixes

with arsenious acid, forming a perfect solution, thus giving us a most useful hematopoietic agent. The soluble alkaloids are perfectly soluble in it, as is also mercuric chlorid. Being a pepton, it is readily diffusible by osmosis.

The only disturbing agent in the intestinal tract is hydrogen sulfid; this will precipitate it, but presumably, much of the iron must have been absorbed before it encounters this gas; if not, appropriate agents should be used for its elimination.

Therapeutically, it does not nauseate, constipate, discolor the teeth, precipitate the digestive agents, nor become inert from contact with them. As to the clinical results, I need not add anything to the many reports already on record.

210 to 220 Randolph Building.

REPORT OF FIVE CASES OF TYPHOID FEVER IN INFANCY AND EARLY CHILDHOOD.

BY EDWARD D. MITCHELL, M.D.

Visiting Physician to the Church Orphans' Home and to the Convent of the Good Shepherd, Memphis.

Within the past few years the occurrence of typhoid fever in very young children has attracted the attention of many observers, and their writings have added much to the already large amount of literature upon the subject. The disease formerly taught by many eminent clinicians not to exist at all, or at least, to be extremely infrequent, is now admitted to be of more common occurrence, and within the past few years many new cases have been added to swell the list of those already published. Typhoid in children has been considered of mild type, but it may be quite severe, and its duration extend over a period of several weeks, as will be seen in two of the five cases herewith reported.

The infection of the parents of these children was of a severe type, and probably accounts for the severity of the disease in their children.

The relative absence of typhoid fever in the first year of life is accounted for by Jacobi in *Pediatrics*, December, 1899, by the fact that the water and food are almost always boiled, thus destroying contaminating germs, and at this time of life the child does not roam

about the floor, where older children may pick up infected material. When, however, the bacillus gains admission to the alimentary tract and there elaborates its toxins, evidence of its presence will be manifested. So when a child, no matter of what age, presents the symptoms of bronchial and intestinal catarrh, with continued fever, our suspicions should at once be aroused and a closer examination made. Were this always done, with the improved methods we have at hand, no doubt a larger number of typhoid fever cases would be revealed in very young children.

The literature upon the subject has been so thoroughly reviewed within the past year that it is unnecessary to again quote the opinions of others, and I shall only report the following five cases, for each is a typical manifestation of the disease, and will I think be of sufficient interest to warrant my publishing them.

The treatment adopted was that usually employed in such cases and consisted mainly of liquid diet, tepid baths to reduce temperature,and stimulants when indications demanded their administration.

The first three cases occurred in a family where both parents and two aunts were suffering with the same disease. The last two were sisters but not related to the others, and living in a remote portion of the city where typhoid fever has not existed for several years.

Case I. V. C., age 8 years; female. Began to sicken with fever and malaise on November 17, 1899. Her tongue was coated, the abdomen slightly tympanitic. The spleen could be palpated. There existed slight bronchitis and diarrhea. On the ninth day of the disease rose spots were detected on the abdomen. About the beginning of the the third week the temperature ranged nearer the normal, not exceeding 100° in the evenings. This continued two or three days when the cough became aggravated, the temperature again rose to higher degree, and physical examination revealed evidence of catarrhal pneumonia. The diarrhea which had been troublesome now became checked, and the bowels were moved by enemata. The fever continued till the seventh week of illness, when it reached normal and convalescence began. Typical Widal reaction was obtained.

Case II. E. C., age 3½ years; female. Her illness began on October 31, 1899, with malaise, cough, slight bronchitis and fever. The bowels were very loose and continued so throughout the illness. The tongue was coated, spleen palpable. Rose spots made their appearance on the fourth day. About the end of the second week there was evidence of catarrhal pneumonia. At the end of the third week the little one complained greatly of earache, and in a few days time the drum ruptured and the ear began discharging, and has continued so till the present time. The temperature became normal in the eighth week, and with the exception of the slight discharge from the ear, she was soon restored to health. Widal reaction.

Case III. C. C., age 13 months; male. Illness began on December 2, 1899, with fever, bronchial and intestinal catarrh—coated tongue, abdominal tympany, spleen somewhat enlarged, but not palpable. The first week of the disease was characterized by very high fever, reaching 104½° in the evenings. On the eighteenth day the temperature became normal and recovery was uncomplicated. The Widal reaction was obtained on second examination of the blood.

Case IV. C. S., age 3 years; female. She had felt badly for several days, showing disinclination to eat, and on January 2, 1900, it was noticed by the parents that the child was feverish and had some diarrhea. Examination revealed a coated tongue, bronchitis, enlarged spleen, gurgling in the right illiac fossa. Temperature 102°. The fever ran a typical curve, reaching normal on the twenty-fourth day. The diarrhea lasted only a few days when the bowels had to be moved by enemata. Recovery was rapid and uneventful. Widal reaction was obtained.

Case V. E. S., age 5 years. Illness began on December 23, 1899, with malaise and cough, and very offensive stools; abdominal tympany was marked and the spleen palpable. About the beginning of the third week the illness was complicated by small patches of catarrhal pneumonia. Temperature reached normal on the thirtieth day of sickness. Widal reaction given.

Randolph Building.

CHRONIC ABSCESS OF THE LIVER, WITH REPORT OF A CASE.*

BY M. GOLTMAN, C.M., M.D.

Physician to City Hospital, Surgeon to Shelby County Poor and Insane Asylum, and the Leath Orphan Asylum.

MEMPHIS, TENN.

It is not my desire to consider the very extensive subject of tropical abscess of the liver as a whole, but rather to emphasize one or two salient features in the report of the following case.

Mr. M. R., aged 34, white, married and father of two healthy children, came to me in November, 1898, complaining of sleeplessness, cough, pain in the right side, particularly about the shoulder, muco-purulent expectoration, and loss of flesh. The complexion was quite muddy, and the sclerotics were faintly jaundiced. The appetite was poor, digestion bad, and there was marked constipation varied with occasional attacks of diarrhea, the last of which had occurred about two months previously. Has had occasional night sweats followed by chilly sensations.

His personal history is somewhat interesting. About six years ago he had a severe attack of "flux," from which he made a slow recovery. About six months after he received a severe blow in the right side by coming into violent contact with a case of drygoods which toppled from a wagon. This laid him up for several days, and after getting well he had another attack of diarrhea, and has had occasional attacks ever since, together with frequent pain in the right shoulder and hypochondrium.

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* Read by title before West Tenn. Medical and Surgical Association, December, 1899.

About three years ago he began to cough, expectorate, lose flesh, and have occasional night sweats. He consulted numerous doctors and was finally told that he had consumption and that his only chance lay in going away to Colorado, or some such place. His mother died in childbirth, and his father of some acute lung trouble, probably pneumonia. A younger brother died of consumption.

Physical examination revealed the patient much emaciated, bent to the right side as if to relax tension, and the veins of the abdomen and chest quite prominent. There was distinct enlargement of the right hypochondrium and quickened and labored breathing. The heart was normal, but the sounds weak. The left lung was hyper-resonant in its entirety and the breath sounds free, regular, but somewhat roughened. The right lung showed dullness at the apex, below this, hyper-resonance, and again marked dullness commencing at the lower border of the fourth rib in the nipple line. This dullness extended backward and upward until in the midaxillary line it reached the seventh rib, behind it reached the angle of the scapula, and below it extended three fingers' breadth beyond the ribs. Pressure over this area was exceedingly painful, particularly when applied between the ribs. The breathing was broncho-vesicular and numerous rales were heard. The spleen was enlarged and some ascites present.

The sputum in several examinations did not show either tubercle bacilli or elastic fibers. The urine was scant, high colored, concentrated, without albumen or sugar, but showing a decided pepton reaction. The blood showed a marked polymorpho-nuclear leukocytosis with considerable anemia. The pulse was 102 and the temperature 99. The diagnosis rested between chronic abscess of the liver, cancer of the liver, phthisis pulmonalis, with perhaps a secondary involvement of the liver, and splenic leukemia. The blood examination excluded definitely the question of leukemia. The patient was about exhausted from the examination and complained bitterly of pain and refused to allow the introduction of an aspirating needle, but promised to return in a day or two for that purpose if I would only relieve his pain for the present, which I did with an opiate mixture. I did not see him again for four weeks, when on being called, I found him suffering extreme pain, and the bulging in the right side had increased to such proportions that it was noticeable without removing his outer garments. The liver could now be distinctly felt below the right margin of the ribs for over a hand's breadth and seemed to feel nodular, but examination was extremely difficult on account of the excruciating pain which it caused. The rapidity of the enlargement was astonishing to me and reminded me of an acute sarcomatosis. He had acquired the opium habit and begged relief, but his wife would not allow me to "probe the liver." Five days later they sent for me again and I took my friend, Dr. Rice, with me to see the case. After some coaxing we were permitted to insert a needle, which, after it penetrated the skin and subcutaneous tissues, met positively no resistance. Pus was found in abundance. Still they would not hear of an operation, and I then suggested a consultation, and Dr. J. M. Maury was asked into the case. The next morning, with the assistance of Drs. Maury and Rice, I resected a portion of two ribs subperiosteally, and finding the liver strongly adherent to the parietal peritoneum, made a small opening which was enlarged with forceps. The sister at the hospital estimated the pus evacuated at two gallons, and I believe it to be a fair estimate. The patient rallied well from the operation, the cough and expectoration ceased, and he gained flesh and strength for ten weeks, when suddenly dysentery set in, and do what I would or could, it was uncontrollable, and he died three days after its onset. This is a favorite termination for these advanced cases, and might possibly be prevented by the institution of appropriate prophylactic irrigation of the bowels.

The interesting points in the case are the history of dysentery six years before the abscess was ever suspected, the probable presence of an abscess all the time which irritated the diaphragm and pleura and set up cough and expectoration and occasional night sweats to the extent of suggesting the presence of phthisis pulmonalis, the very rapid enlargement, the large quantity of pus and the apyrexia.

From the diagnostic point of view, the following are the points I desire to especially call your attention to. The primary attack of dysentery six years before, the injury to the right side six months later, (I have come across almost a similar history as regards injury in another case) the repeated attacks of diarrhea alternating with constipation; and the pain referred to the right shoulder. This latter symptom I have never found absent, having observed it in all cases of my own, as well as in several cases in the hands of others, and lastly the aspiration of pus, and the want of resistance to the passage of the exploring needle. Nothing else but experience can teach one the full appreciation of this almost pathognomonic sign.

From the therapeutic standpoint the following suggest themselves: Never give a prescription for an opiate in this class of cases. They soon learn that it relieves their pain and they resort to it rather than go to the doctor. In suspected cases use the exploring needle early and diligently, under an anesthetic if necessary, and if pus is found evacuate it immediately.

The choice of operation depends upon the site of the pus. If in the right lobe, which is the rule in seventy per cent. of the cases, subperiosteal resection of one or more ribs, and if adhesions are present the immediate evacuation of the abscess, are the indications. If adhesions are not present, the visceral and parietal peritoneum are firmly sutured on each side of the incision and the abscess opened between and drained. When the pus is fetid, irrigate with formalin, otherwise irrigation is not necessary. Some authorities advise curetting the abscess cavity, thorough irrigation and packing with iodoform gauze. The rationale of this method appeals to me, but I cannot speak of it from personal experience. Much bleeding would naturally follow this method. Others advise doing the operation in two stages where adhesions are absent as follows: cut down over the site of the abscess and through the parietal peritoneum; suture the parietal and visceral peritoneum, or place sponges between

them until firm adhesions have formed, which is in about four days, then open and treat the abscess cavity. We prefer the operation done at one sitting. Others again advise trans-pleural drainage in these cases, but we cannot recommend it. Simple aspiration of the abscess is so rarely curative, that it need not be considered.

Porter Building.

TWO CASES OF HYSTERIA WITH PROMINENT EYE SYMPTOMS.

BY E. C. ELLETT, M.D.
MEMPHIS.
Ophthalmic and Aural Surgeon to the City Hospital, St. Joseph's Hospital, etc.

The ocular manifestations of hysteria are no less protean than those affecting other parts of the body, and like the other symptoms, may simulate serious organic disease. In the eye we see hysterical amblyopia, usually monocular; contraction of the field of vision, varying from day to day; reversal of the color fields, whereby red and green objects are seen further out from the point of fixation than white objects, this fact being pointed out by DeSchweinitz and John K. Mitchell; retinal anesthesia, causing irritable eyes, poor and painful vision; anesthesia of the conjunctiva, a symptom omitted in many books; disturbances of the extra-ocular muscles, causing ptosis, squint, etc. The whole subject has been most carefully reviewed by Dr. Casey Wood in the *American Journal of the Medical Sciences* for January, 1899. I wish here to report two somewhat similar cases, presenting typical pictures.

Case I. Miss ——, aged 15, was first examined on January 17, 1898. She is a delicate looking blonde, of the *spirituelle* type. Her complaint was that her eyes pained, the lids drooped at times, letters and lines at which she looked moved and fell to the right. She was also troubled with "after images." A year before that she had been told by a very competent eye surgeon that she was threatened with serious trouble with the optic nerve (patient's statement). I found vision reduced more than half for distance in each eye ($\frac{15}{40}$), and she could read fine print at only one fixed distance from the eyes. The balance and strength of the extra-ocular muscles was normal, and the eye ground also normal. I could not improve the vision by glasses, but under homatropine corrected the refraction by the "shadow test." The error was small, far-sighted astigmatism, and while the glass did not improve her distant vision, the eye pain and asthenopia were relieved. The fields of vision were contracted as follows:

Right eye (for white)	Up,	25°
	Out,	50°
	Down,	35°
	In,	35°
Left eye,	Up,	20°
	Out,	45°
	Down,	45°
	In,	30°

[The normal is up 50°, out 90°, down 65°, in 55°.]

At this examination the color fields were correspondingly contracted. Two months later I found greater contraction of the fields, from 20° to 30° all round in the right eye, and from 10° to 20° in the left, with the color fields at times more extensive than the white, and the green larger than the red, which is the reverse of normal.

Aside from the eyes, this young lady was addicted to having some sort of "fainting spells." Except for the relief of the eye pain the condition, both generally and ocularly, remained the same. I told the family my opinion, and made no further suggestions. The following fall she consulted Dr. H. M. Thomas, of Baltimore. He wrote me asking the result of my examination, concurred in my diagnosis, and said that Dr. Theobald had examined her eyes with the same findings that I reported. She came home, and was under no treatment after this time. In February of this year she consulted me as to the wisdom of laying aside her glasses. Without any apparent cause she had, in the last four months, gained nineteen pounds; her vision and visual fields are normal, and she uses her eyes with comfort. She has had no "spells" recently.

If some Christian Scientist had had this patient under "treatment" at the time she made up her mind to get well, another wonderful recovery from impending blindness, etc., would have been recorded.

Case II. In June, 1897, a little girl, 7 years old, was brought to me for *otitis media purulenta residua*. Aside from this trouble she was apparently well, a strong and healthy looking brunette. In August, 1898, she was again brought to me with a complaint of constant frontal headache, nervousness and irritability. The vision was reduced to one-tenth, due apparently to near-sightedness, which was the only abnormality revealed by the examination. This was carefully corrected under a mydriatic, as is my custom, but the vision was at best only one-half of normal. The frontal headache was relieved, and the nervousness greatly ameliorated. In October, 1899, the vision was again reduced, this time to one-twentieth, unimproved by correcting the near-sightedness. The eye grounds were normal, the conjunctivæ so insensitive that I could rub my finger all over the eyeball without her feeling it, and the visual field contracted to about 20° in the right eye and 30° in the left. The limits of the red and green fields ran in and out, now beyond the white, now the red more contracted, and now the green. The child had become pale, very nervous and irritable. I advised the mother to see her physician, Dr. Posert, with whom I conferred. He agreed in the diagnosis, but so far as I can learn the patient has not yet made much progress toward relief.

The father and a brother of this patient are myopic. The mother is intensely neurotic. As an example, she is beset with a fear that her child is going blind, a fear which repeated assurances from me have not removed, and she is so fearful of this calamity that she goes to the child's bed at night and awakens her to ask her if she can see.

There is but little to add to the recital of these two cases. They are quite typical, which is my main reason for recording them. They illustrate the necessity of one being familiar with normal as well as abnormal conditions, to avoid the error into which my predecessor in Case I is said to have fallen. They also illustrate the usefulness of the shadow test as an objective means of measuring the refraction in eyes whose visual acuity is below normal, and they also show the value of a patient mapping out of the visual field in such cases, the evidence afforded by the fluids being almost decisive in these two cases. Lastly, they illustrate the limitations of therapeutics, and in Case I the *vis medicatrix naturæ*.

Porter Building.

On the Resuscitation of Apparently Dead Newborn by Laborde's Method.—Fronczak (*Phila. Med. Journal*, Feb. 24, 1900) describes Laborde's method of resuscitation, that of rhythmic traction of the tongue, and reports four cases in which it was successfully practiced in apparently dead newborn infants. He puts the child in a warm bath, clears the nose and throat of mucus, and grasping the tongue, slowly practices drawing it firmly forward and then releasing it. The tongue at first gives no resistance, and after a while resists positively. Soon is noticed very mild respiratory movement, then quiet. In a short time the breathing will be established. One should not be discouraged if this does not occur promptly, but should continue with his efforts. The advantages over Schultze's method are that the child does not run any chance of becoming chilled, the action of the heart can be watched, and the method is not so fatiguing to the operator.

THE

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EDITORIALS.

THE PASSING OF THE GARGLE, AND THE SELECTION OF ITS SUCCESSOR.*

In this iconoclastic day and generation many time-honored methods and remedies are being relegated to the realm immortalized by a former President of these United States, and the one next destined to have its sphere of usefulness materially curtailed is the gargle. It is now well recognized that this method of applying remedies to the throat only succeeds in reaching the mouth, anterior surface of the palate, anterior faucial pillars, tongue and tonsils, if not enlarged. For the average case of tonsillitis and pharyngitis it is absolutely inert, though by virtue of being accompanied with some effort on the part of the patient, and a good deal of noise, its mental effect is considerable. It is not the tendency of the day to tear down any of our idols without erecting in their stead what we believe to be more deserving ones. Of the substitutes for the time-honored method may be mentioned that of Von Tröltsch. As described by Newcomb, this method consists in the patient taking some of the solution in the mouth, and leaning the head back, he starts to swallow. When the solution is well within the pharynx, a quick forward toss of the head will throw the solu-

* Suggested by an article on "Limitations of a Gargle," by Saxton T. Pope, in the Occidental Medical Times, March 1, 1900.

tion up into the naso-pharynx and posterior nares. Swain has demonstrated that a solution thus used will reach both the epiglottis and arytenoids, as well as the naso- and oro-pharynx. Used in this way, gargling becomes quite a feat of legerdemain. We have seen the method described as follows: have the patient take some of the solution in the mouth, close both nostrils, open the mouth and attempt to swallow. This also throws the solution up behind the palate, and seems to be simpler than the other method. By painting the pharynx with a solution of iodin, and using starch water as a gargle, the ordinary method of gargling will be found not to color the starch water at all, while the method of Von Tröltsch will color it blue, showing that it has reached the iodin.

We would prefer, in cases where the naso-pharynx is to be reached, to do so by means of the nasal douche. The solution must be alkaline and warm. It can be either snuffed up from the hand, and then by sniffing coaxed back into the pharynx, or used by some such appliance as a feeding cup, spoon, or Bermingham douche. If the precaution is observed of keeping the mouth open while using the douche, no disagreeable strangling will occur; and if the proper method of blowing the nose is followed, i. e., leaving the side to be blown free from the alternate closing and opening usually practiced, the ears will be safe. This method is to be supplemented by suitable applications made by the physician at such intervals as he sees proper. For tonsillar and oro-pharyngeal inflammations we are convinced that the maximum of effect with a minimum of disturbance is attained by the prescription of such agents as can be easily swallowed. A sip, taken at half-hour intervals, applies itself thoroughly and almost constantly to these parts, and we are impressed with the better and quicker results thus attained. This also may be supplemented by local applications. In severe inflammations, sucking ice applies cold to the parts effectively. In cases of "quinsy," where a sort of internal poultice is desired, the old method of gargling with a *hot* alkaline solution will sometimes abort the trouble, or if too late for this, will hasten its breaking down.

To recapitulate, then: The old method of gargling is suited for conditions affecting the mouth, tongue, anterior surface of the soft palate and anterior faucial pillars. For the naso-pharynx, the method of Von Tröltsch, or better, the nasal douche. For the

tonsils and oro-pharynx, the frequent use of small quantities of some mixture that can be swallowed. As we are discussing methods and not remedies, we make no suggestions as to the latter.

REPORTS OF SOCIETIES.

PROCEEDINGS OF THE MEMPHIS MEDICAL SOCIETY.

Regular Meeting, March 6, 1900.

The President, Dr. E. C. Ellett, in the Chair.

Present were: Drs. Alfred Moore, Rice, Sale, F. A. Jones, Griswold, Rudisill, Webb, Kane, Ellett, Black and Barton.

The President presented a patient illustrating the *Deleterious Influence of Lead Solutions Used During Ulceration of the Cornea.* The man had used a solution of acetate of lead in the eye whose cornea was ulcerated four months ago, on the advice of some old woman. There was a large white scale-like opacity half as large as the little finger nail in the center of the cornea, and surrounded by a halo of hazy cornea 2 m. m. wide. There was considerable irritation and a constant feeling as if a foreign body were in the eye. All the text-books speak of this danger and the mistake is rarely made, but the exhibition of a case might serve to show that the danger is real.

Dr. S. E. Rice read, for *Dr. R. B. Maury*, a paper on *A Case of Advanced Extra-Uterine Pregnancy; Operation Seven Weeks After Completion of Term.* (See p. 163.)

Dr. J. L. Barton asked when is the proper time to operate in extra-uterine pregnancy.

Dr. E. P. Sale spoke of a case of coincident extra- and intra-uterine pregnancy in a rachitic dwarf. The abdomen presented two tumors, but the condition was not diagnosed until operation. The two children were removed from the sac and uterus and lived three and four months respectively. The patient died of sepsis. The case occurred about twenty years ago.

Dr. Alfred Moore asked what was the mortality in advanced extra-uterine pregnancy.

Dr. Rice said that operation should be done as soon as the diagnosis is made. Some operators prefer the vaginal route. Elec-

tricity is now usually regarded as futile; it may kill the fetus, but does not cause its absorption. As long as the placenta or chorion exist, separation of them may cause hemorrhage.

Dr. Sale cautioned care in diagnosis, and mentioned a case diagnosed extra-uterine gestation by several physicians, but the patient refused operation and the symptoms all passed away. He don't think a positive diagnosis can be made before rupture occurs. Thomas has suggested injecting morphin into the sac and thus killing the fetus.

Dr. Rice reported a case of *Capillary Bronchitis* in a child 18 months old, following measles. Immediately after the measles there was dyspnea, with coughing up of membrane and pus, and hyperpyrexia (105°–106°). The capillary bronchitis, and then pneumonia, followed. The membrane contained no Loeffler bacilli, and antitoxin (2000 units) had no effect. He regards the case as probably a streptococcus laryngitis, with secondary infection of the lungs. He has seen a good deal of lobar pneumonia following the prevalent epidemic of measles.

Dr. F. A. Jones agreed with Dr. Rice as to the nature of the infection. He has seen some very severe complications with measles lately, including several cases of tachycardia. One case was mentioned, occurring in a healthy man of 26. After convalescence was established he was suddenly taken with profuse hemorrhage from the bowels, then aphasia, complete paralysis and death. In three cases he has seen diarrhea and abscess of the liver.

Dr. Sale thinks measles is a disease to be respected on account of its occasional severity and its complications. He thinks Dr. Jones' case might have been one of septic endocarditis.

Dr. Rice thinks the hemorrhage from the bowels might have been by transudation, as occurs in malarial hematemesis, etc.

Dr. Jones had looked for but had not found any signs of endocarditis. The bowel hemorrhage may have come on as the result of vaso-motor paresis.

The President said he had recently seen a number of cases of acute otitis media from measles. It had usually appeared after the child was well enough to be out. In not a few cases the temperature, reaching a maximum of 101°–102° about 3 P.M., was the only sign of any trouble, i. e., there was no pain. The drum membranes were found to be quite red and bulging. He had that day

seen and operated on two such cases in consultation (with relief from the fever). He wished to emphasize the fact that though no pain existed, still an acute otitis media might be present and keep up the temperature.

Regular Meeting, March 20, 1900.

The President, Dr. E. C. Ellett, in the chair.

Present were: Drs. Raines, Henning, Wolff, Goltman, Hughey, Buford, Barton, A. Moore, Rudisill, Braun, Porter, Raymond, F. A. Jones, W. B. Sanford, Williams, Henning, McKinney, Ellett, Krauss, Rice, Harkness, Turner and M. Moore.

Visitors, Drs. Green, Ball and Fountain.

Dr. S. E. Rice read a paper on *The Etiology and Pathology of Common Colds.* He reviewed the pathology of inflammation, the anatomy of the nasal mucosa, and the inflammatory processes as modified by the peculiarities of this membrane. He thinks the presence of secretion indicates necrosis of the epithelium. The cause of the inflammation is an irritant, either applied locally or peripherally. In the latter case he thinks the local irritation is due to the irritant in the blood and to the vaso-motor paralysis produced by these irritants.

Dr. B. F. Turner spoke on *The Prophylaxis of Common Colds.* He said that our ideas on prophylaxis vary with our ideas on etiology. Practices vary from the hardening idea, with free exposure of the body, to the other extreme of complete protection. He does not favor the hardening processes as usually practiced, but thinks we can easily fall into the equally bad habit of too much protection in the way of clothing. The whole matter may be said to be the preservation of the physiologic equilibrium of the body.

Dr. B. G. Henning discussed *The Treatment of Common Colds.* As a rule treatment is not satisfactory. Many different plans are in vogue. A "cold" is due to exposure to cold and wet, or the inhalation of irritating vapors and substances. The occurrence of epidemics suggests their contagiousness. The coryza of measles is undoubtedly due to a germ, and it is probable that all "colds" are due to some micro-organism. The principal thing in the treatment of a "cold" is to prevent the extension of the inflammation to the accessory sinuses and to the respiratory and digestive tracts. We recognize three stages—a dry stage, a stage of serous exudation

and a stage of muco-purulent inflammation. The first is the most uncomfortable, being characterized by nasal obstruction, pains and sneezing. Confinement to bed is desirable, and very necessary in the very old, the delicate and the very young. In the first stage opium stands at the head of drugs, and is best given as Dover's powder. Purgation by calomel depletes the tissues and relieves the aching. He usually gives ten grains each of Dover's powder and quinin, with two grains of the monobromate of camphor, and a calomel purge. Opium lessens the pain and hastens the later stages of the "cold." The inhalation of steam, with or without the addition of camphor or carbolic acid, is beneficial. Iodin vapor is irritating. He has seen bicarbonate of soda internally recommended, but does not know on what grounds. In the second stage one drop of tincture of aconite, with two of tincture of belladonna every two hours is beneficial. Menthol, one part and boracic acid two parts, as a snuff, "opens the head" and adds to the patient's comfort. Two grains each of monobromate of camphor, acetanilid and bisulphate of quinin every two hours has a good effect. Ipecac stands at the head of drugs in the treatment of acute inflammations of the broncho-pulmonary apparatus. Small doses of the iodides are frequently given in the second and third stages of bronchial catarrh. In these stages of coryza astringent sprays are of service, as well as insufflations of powdered white sugar. Hot foot baths and hot drinks are valuable, the latter being especially stimulating to the circulation if sipped. The Turkish bath is not to be used, as the exposure after it usually makes the patient worse.

Dr. G. G. Buford thinks the cause of "colds" is vaso-motor disturbance. There is primary contraction of the vessels, and the pain is caused by the blood being forced into these small vessels. The dilation follows. In the prophylaxis he believes in plenty of fresh air and light clothing and covering. In the treatment he finds violent physical exercise beneficial. The hot bath and thorough protection afterward is effective, as well as Dover's powder and a laxative. The coaltar products produce vascular relaxation. Confinement to bed is especially valuable in the first stage.

Dr. Wm. Krauss asked if a "cold" is due to local irritation, how does exposure, when perspiring, produce it? He thinks the irritation is peripheral. He has succeeded in breaking up a "cold" by a cold bath. He thinks we dress too warm, and should dress

for the room temperature, and put on heavy outer garments when going out. He thinks woollen underclothing unsuitable, but advises heavy shoes.

Dr. F. S. Raymond asked how warm should the room be for the confinement of the patient with a cold or other acute inflammation of the respiratory apparatus.

Dr. Richmond McKinney does not think remedies can break up a "cold." For the local (nasal) treatment he advises relieve the nasal stenosis with cocain, applying nitrate of silver, ten grains to ounce, and then a 6 per cent. spray of camphor-menthol in albolin. In addition to this he gives Dover's powder and a laxative.

The President would like to know on what grounds quinin is given for "colds." It is not indicated theoretically, and practically he is not convinced of its usefulness. He agrees with what was said of the value of Dover's powder, hot foot baths and hot drinks, and mentioned pilocarpin, controlled by atropin, as a valuable drug in the first stages of a "cold." He does not think enough stress has been put on the part the activity of the skin plays in preventing colds. It is the largest excreting organ in the body, and when the blood, loaded with excrementitious products, is driven from the surface by exposure of the skin to the vaso-constricting influence of chilling the surface when wet, these products cause irritation. Plenty of fresh air, a daily whole or partial cold bath, and light clothing, about cover the prophylaxis of "colds." As to clothing, we can demonstrate by trying to dry the wet hands on a woollen cloth, how little power wool has to absorb moisture. A fabric should be worn next to the skin which will rapidly take up the insensible perspiration and keep the skin dry. Such a fabric is on the market in the shape of linen mesh, which he has worn this winter for the first time, and has not had a "cold," though always subject to them. He finds himself perfectly comfortable in cold weather. [A garment of this material was shown.] He referred to the probable contagiousness of "colds," as shown by the experience of Nansen's party, who were free from them while in the polar regions, but had them on their return to inhabited localities. The treatment of "colds" by permanganate of potash irrigation, on the idea of their infectious origin, was referred to.

Dr. Rice don't believe in the use of opium unless there is pain, and thinks the value of Dover's powder depends on the ipecac it

contains. He thinks the linen mesh would radiate too much heat to be comfortable for many people, to whom woollen is better suited. The dry stage of a "cold" is due to the congestion cutting off glandular secretion. Relief comes from epithelial desquamation. The cold bath is a well-known tonic, as is oxygen. The stimulating effect of the latter is sufficient to overcome the effects of exposure, dampness in the "open air" methods of treating certain diseases. An even temperature is of more importance than a high temperature in treating colds.

Dr. Turner said that "colds" are due to quick changes, and their occurrence is explained by Rohé on purely physical grounds. Cold air has a low humidity, and when it enters the nose and is warmed, its capacity for moisture is increased, and it draws moisture from the nasal mucosa. This draws the salts of the blood to the surface and leaves them, where they act as irritants. Exercise, or anything which will enhance the functions of the skin, will aid in throwing off a "cold."

Dr. Henning thinks southern houses do not lack ventilation. He attaches more importance to an even than to a high temperature, but thinks 68°F. desirable in the room, as this gently excites the function of the skin. He uses quinin only in the first stage of a "cold," and then for its diaphoretic effect. Later it is a disadvantage. Pilocarpin promotes the activity of the skin, but it is too depressing for indiscriminate use. Cold baths are invigorating to him, but do not protect him from taking "cold." He wears the heaviest woollen underclothes, and is always in a sensible perspiration. He thinks the second stage of a cold is that of exudation from the walls of the blood vessels. Opium acts as a diaphoretic and lessens irritation, and for this reason he uses it.

Dr. Battle Malone was elected to membership.

Menière's Symptom-Complex in Leukocythemia.—At a meeting of the Royal Medical and Chirurgical Society held on February 27th, Dr. F. Parkes Weber read an interesting paper on acute Menière's symptoms in splenomedullary leukocythemia. His paper made special reference to the anatomic changes found in acute leukocythemic affection of the ear and was supplemented by a report from Mr. Richard Lake on the pathologic condition of the internal ear in one case. Mr. Lake said that the condition, viz., ossification of the ligamentum spirale, had not been described before.—*Phil. Med. Journal.*

PROGRESS OF MEDICINE.

A Symposium on Cystitis.—Read before the Ramsey County Medical Society (*St. Paul Medical Journal*, February, 1900).

1. General remarks, by Haldor Sneve:

While cystitis is generally associated with ammoniacal urine, there are several forms in which it is acid. According to Bryant, cystitis is a common consequence of stone, prostatic disease, stricture or gonorrhea, and is usually chronic or subacute — the more acute symptoms mostly supervening on the chronic. The chronic form is the direct consequence of local irritation by tumor, stone, or obstruction to the outflow, or from paralysis; the acute is caused by operations, gonorrhea and acute prostatitis, and finally from "catching cold." Ammoniacal fermentation is due to the introduction of bacteria, either from without by instrumentation, or by extension of inflammation of adjacent tissues. The mucous membrane is devoid of glands, and is loosely attached to the muscularis, which contains the lymphatics and which plays an important role in the pathology of interstitial cystitis and in the extension of infective processes to and from the bladder. The mucosa contains no lymphatics and secretes no mucus; it lacks, therefore, all the physiologic elements necessary for absorption; this has been abundantly demonstrated experimentally. Since there is no free oxygen in the bladder, only anerobic bacteria can grow in it. Cystitis may be accompanied by acid urine if caused by microbes which do not decompose urea; among these are the tubercle bacillus, gonococcus, streptococcus pyogenes, and bacterium coli. Summing up, cystitis is a disease caused by microbic infection, and the acidity of the urine is no evidence of the absence of vesical disease.

2. Etiology and classification, by G. A. Renz:

A bacterial disease; the infection usually, but not necessarily, from without. Insult to the mucosa furnishes the nutrient base. Among these retention of the urine is perhaps the most frequent, distention favoring absorption, abnormal contractions, foreign bodies, tumors by causing retention, tenesmus, pressure from without, irritants in the urine, drugs, albumin, sugar, exposure to cold when

bacteria are already present, and in the same way venous stasis, trauma by operation, the passage of instruments, and instillation of caustic drugs; but the essential cause is the presence of microbes. Clean instruments may infect if passed through an undisinfected urethra. The urine in the bladder may itself contain pathogenic microbes that are eliminated even months after such infection, as typhoid, etc. Infection may come from adjacent organs, as the rectum, usually by the colon bacillus. The bacteriologic classification of cystitis is that of Senn — bacillus coli, saprophytic bacteria, staphylococcus, streptococcus, streptococcus erysipelatus, diplobacillus, typhoid, gonococcus and tuberculosis infection. Gonococcus infection is usually limited to the trigonum and associated with other pus germs. Primary tuberculosis of the bladder is doubted, as it resists the infection for a long time. Kidney tuberculosis may exist for years without the bacilli infecting the bladder. Adjacent organs are usually involved.

3. Morbid anatomy, symptomatology and diagnosis, by J. L. Rothrock:

By means of the cystoscope we have found that lesions are more common than formerly supposed. Cystitis is divisible into four varieties—desquamative, suppurative, ulcerative, and membranous or exfoliative. The first is evidenced by marked and continuous shedding of the epithelium, with absence of the evidences of inflammation; there are capillary injection and roughness; it occurs in old women and follows slight trauma, but most frequently instrumentation; clinically it is very chronic, resistant to treatment, and predisposes to pyogenic infection. The suppurative form includes all lesions characterized by the infiltration of the mucosa by inflammatory products, with epithelial desquamation and pus formation; in addition to swelling and redness there is a deposit of pus and desquamated epithelia; under this the surface is rough and shows punctate hemorrhages, and in severe cases an ulcerated and granulated surface surrounded by a zone of congestion. This variety is due to pyogenic bacteria, runs an acute course, and if of long duration the mucosa becomes thickened, and may be pushed into the interstices of the hypertrophied muscles, forming diverticulæ, especially if obstruction is present.

Ulcerative cystitis is less common; it may follow catarrh, and is frequently associated with foreign bodies. The ulcers are usually

rounded or irregular, with well-defined border; a chronic form is the linear ulcer. Membranous cystitis is mostly caused by the streptococcus, sometimes by the pneumococcus. The intensity varies, being superficial in mild, the entire bladder becoming speedily gangrenous in severe cases. The lesions produced by the gonococcus and tubercle bacillus are characteristic; the former produces insular suppuration, the latter begins with infiltration of the mucosa with miliary tubercles, which coalesce, caseate and break down, forming an ulcer; the lesion is usually solitary and selects the trigonum. It has a yellowish gray base with little congestion about the border.

The subjective signs are very much the same in all the varieties; there is little general disturbance, occasionally fever, always frequent desire to micturate. The differential diagnosis cannot be made by the examination of the urine (sic); only the cystoscope can determine whether the pus comes from the urethra, kidney or bladder. The urine is generally acid, alkalin only when there is residual urine and in cases of long standing. In desquamative, the urine is acid, and as a rule contains no albumin; it contains very many desquamated epithelia and very few leukocytes; it may be turbid from the many epithelia present. In suppurative, it is acid in the acute stage, alkalin only when ammoniacal decomposition of the urea has taken place; blood, pus and desquamated epithelia are present. Mucus is rarely found in the urine from cystitis; the tough, tenacious material frequently found is pus altered by the action of the alkali; in such urines triple phosphates are present as a rule. In ulcerative cystitis the urine is acid and contains occasionally blood, invariably pus and a few desquamated epithelia. In the membranous, shreds of epithelium are found, occasionally blood and pus. The gonococcus and tubercle bacillus are the only bacteria having diagnostic value.

4. Prophylaxis and treatment, by Burnside Foster:

Prophylactic measures: 1, avoid catheterization; retention may be often relieved without a catheter; 2, where this is necessary observe the following rules: *a*, use a metal instrument which can be sterilized by heat; *b*, if another instrument must be used, provide a new one for each patient if possible; *c*, use an aseptic lubricant, one which is soluble in water, as glycerin; *d*, thoroughly cleanse the glans, penis and urethra before using the catheter, and wash out the bladder after instrumentation.

Treatment: The cause must, if possible, be removed; rest in bed must be insisted upon, the diet should be liquid or semi-solid, all stimulating food and drink must be forbidden, large amounts of bland fluid and alkalin water should be drunk, fruits are allowed, the bowels are freely opened and kept active, and the internal medication is symptomatic. When the urine is acid, alkalies are indicated; a convenient formula contains 4 minims of liquor potassæ, 15 minims of mucilage, and 45 minims of tincture of hyoscyamus, given every four hours. If the urine is alkalin, antiseptics are indicated, such as salol, boric acid, or sodium benzoate; urotropin is useful, especially in bacteriurea. The local treatment consists of washing out the bladder with antiseptic solutions, which must be done through a catheter if the bladder does not completely empty itself; silver nitrate, corrosive sublimate, salicylic acid and potassium permanganate are the most useful, in the order named. In very acute cases, with great pain, the method of instillation is useful, beginning with 25 to 50 drops of a 1 per cent. solution, after the bladder has been completely emptied. Rovsin washes out with sterilized water, instills two ounces of 2 per cent. silver, followed in a few minutes with the same amount of water. Drainage may be through the urethra or through an artificial opening, the latter being either suprapubic or perineal; the former has many advantages. For temporary drainage the author prefers the perineal, the patient remaining in bed; if marked prostatic enlargement, the opening should be in the median line, at the apex of the prostate.

Tubercular cystitis does not yield to the ordinary local treatments. Drainage is sometimes useful. Author had one case where the patient was curetted through a perineal opening, some ounces of pultaceous material removed, and the patient much benefited. Constitutional treatment is essential.

He summarizes as follows: 1, rest, especially in acute cases; 2, correction of abnormal conditions of the urine, chemical and bacteriologic; 3, intestinal antisepsis and free catharsis; 4, drainage of the bladder where it cannot be voluntarily emptied by the patient; 5, the direct application to the mucosa of such substances as have been found to destroy germs and diminish inflammation.

The Non-Operative Treatment of Strabismus, its Possibilities. A. Edw. Davis (*Post Graduate*, March, 1900) draws the following conclusions:

1. Hypermetropia and hypermetropic astigmatism are the causes of convergent strabismus in the great majority of cases.

2. As contributory causes may be mentioned, (a) difference in acuteness of vision, either congenital or acquired, but usually eyes; (b) anything that interferes with the acuteness of vision, as opacities on the cornea, in the vitreous or lens.

3. Faulty structure, insertions or innervations of the extrinsic muscles of the eye may cause convergent strabismus; and paresis of the ciliary muscles has been given by some observers (Javal); also traumatism of the external rectus muscle at birth (Panas).

4. The amblyopia present in most cases of convergent strabismus is functional and acquired, and not congenital except in rare cases. The few examples of positive evidence on this point, that is, where cases have improved greatly in vision when the squinting was straightened, together with cases where the amblyopia has been observed to develop after the strabismus begins, are of much more value than all of the negative evidence in favor of the theory of congenital amblyopia.

5. The non-operative treatment of strabismus, atropin, the exclusion pad, and in patients old enough, glasses, the stereoscope and bar-reading should begin as soon as the squinting is observed; for it is in the early stages that this form of treatment is capable of doing so much good. By means of it, if the case is taken in time, false fixation and suppression of the image in the squinting eye is prevented, fusion of the images in the two eyes encouraged, and form-perception, that is, true binocular single vision, often maintained. Even where one or more of these functions have been lost, persistent effort in the non-operative methods of treatment frequently restores them.

6. That about 25 per cent. of cases of convergent strabismus may be cured by non-operative treatment.

7. Just as soon as the non-operative method of treatment ceases to improve the condition of the squint, it is time to operate. Delay in operating after this is not only useless but harmful, because the habit of suppressing the image in the squinting eye becomes fixed and the amblyopia worse.

8. After the eyes have been operated on, the use of the stereoscope, bar-reading, the pad, glasses, etc., are of the utmost use in completing the cure, maintaining parallelism and establishing single binocular vision.

9. The "rational" treatment of strabismus is, as Priestly Smith says, "early treatment", and in every case the child should be thoroughly examined soon after the strabismus begins. This principle should be urged upon the whole profession, in order that it may reach the public.

Etiology of Headache.—Dercum (*Nervous Diseases, by American Authors*, pp. 927, 928) says that headache is a very common nervous symptom. It occurs in varying degrees of intensity as a manifestation of the most diverse morbid states. It arises at all periods of life, but is most common between the ages of puberty and middle life—that is, between the fifteenth and forty-fifth years. Early childhood and advanced life enjoy a comparative exemption, which is to be ascribed partly to the fact that these periods are relatively free from many of the underlying pathologic conditions and partly to the fact that at the extremes of life the cerebral cortex is less active functionally; that is to say, less irritable.

The headaches of childhood are not only much less frequent than those of adult life, but they are also more limited in variety, and as a rule less severe.

The influence of sex is notable. Women suffer more than men in the ratio of three to one.

It would appear that headache is more common in city life than among country folk, among the well to-do than the poor, in the spring and autumn, and in temperate climates. Highly educated persons and those whose time is devoted to letters and learning suffer more than others to an extent which cannot be fully explained by their sedentary habits.

Headache occurs as a symptom more or less prominent under the following conditions, which, taken together, may be regarded as forming the basis of an etiological classification:

1. Traumatism involving the head.

It is to be noted that headache is a constant symptom after recovery of consciousness in cerebral concussion and pressure, but that it occurs infrequently as a direct symptom after surgical oper-

ations affecting the cerebral cortex or after laceration of brain substance if pressure have been removed.

2. Circulatory disturbances, as:

(a) Passive congestion, such as produced by posture, tight clothing about the neck, or the presence of tumors upon the veins of the neck.

(b) Active hyperemia, such as results from excessive or prolonged physical or intellectual strain, or attends the initial stage of acute meningitis, or the action of certain drugs, as alcohol, amyl nitrite, nitro-glycerin. The vessels of the pia are dilated, there is increased tension, and pressure upon related sensitive nerve filaments.

(c) Anemia, either that following loss of blood or the ordinary forms of anemia, and especially chlorosis. To temporary brain anemia is due the headache which occurs in chlorotic subjects upon effort, as ascending a flight of stairs. Local anemia may accompany brain exhaustion from prolonged mental effort, and may be invoked to explain the headache which frequently arises under these circumstances.

3. Inflammation. Headache is a very prominent symptom in meningitis, whether due to local cause, secondary infection, or the primary infection of cerebro-spinal fever.

4. Toxemia. The offending substance or substances in the blood may be the result of

(a) Infection, as in the acute specific fevers and malaria.

(b) Incomplete or perverted physiologico-chemical processes, or defective elimination of waste. This variety of headache occurs in uremia, diabetes, gastro-hepatic derangements, gout, rheumatism and lithemia.

(c) The action of drugs and poisons.

a Acute: quinin, opium, narcotics generally, the nitrites, alcohol, ether, carbon dioxide.

b Chronic: lead, tobacco, alcohol, opium, chloral.

5. Changes in the arteries. Endarteritis, arterio-sclerosis; hence in syphilis, degenerative nephritis, chronic alcoholism, lead poisoning.

6. Organic diseases of the brain, such as abscess, tumor, aneurism (not miliary), especially when pressure is directly exerted upon the brain-membranes.

7. Caries of the cranial bones.

8. Neuropathic conditions, neurasthenia, hysteria, epilepsy.

9. Reflex irritation; ocular, nasal, pharyngeal, auditory, gastric, and irritation from the reproductive tract.

The etiology of a large proportion of headaches is not simple, but complex, two or more of the foregoing factors often being concerned in its causation.

Traumatic Tetanus.—Robt. Abbe (*Annals of Surgery*, March, 1900), after thoroughly discussing nine cases of traumatic tetanus, concludes with the following remarks:

Considering the foregoing cases, I would note that the common observation that a long period of incubation is an absolute criterion of the probable severity is an error.

In considering these nine cases, I find two only can be regarded as in sense of a milder type, one commencing on the 10th, and one the 19th, the day after injury. The other seven were of a grave type.

Of the seven occurring during the epidemic of the past summer, five were so severe, either at the onset or in the progress of the disease, that they were deemed worthy of being subjected to the test of trephining. Of these five, three recovered and two died.

The cases that recovered had their onset on the seventh, ninth, and nineteenth day of incubation; the cases which died, on the eighth and sixteenth day of incubation.

In two of the trephined cases the Board of Health toxin was used; one died and one recovered. In three cases Parke, Davis & Company's serum was used; two recovered and one died.

There were five of the nine cases in which one could perceive an apparent effect of the serum treatment.

In case No. I, in which it was given only subcutaneously, the Board of Health serum (1898) was used. Though the patient subsequently died, improvement was certainly noticed.

In case No. IV, Board of Health serum (1899) was used by trephine and subcutaneously, and the patient recovered.

In case No. VI, the Parke Davis & Company's serum was used only subcutaneously. Improvement was demonstrated, and the patient recovered.

In cases Nos. VII and VIII, the Parke Davis & Company's serum was used and the favorable effect observed. Both were tre-

phined and the serum used in the brain subcutaneously. Both recovered.

The favorable action was shown either in a prompt arrest of the general convulsion spasm or in an abatement of the progressively bad symptoms.

The serum furnished by Parke Davis & Company was available in the midst of the summer epidemic of tetanus, if we may call it so, at the moment when the Board of Health ceased to furnish more from lack of supply, and it proved itself, both by comparison and in its actual results, noticeably more efficient.

This limited experience leads me to regard it as a valuable adjunct in the scientific treatment of this grave malady, and I can but regard the cerebral injection as an advance over the subcutaneous method worthy of extended trial and further study.

[According to Roux and Borrel the poison of tetanus is fixed in the nerve tissues and in the brain cells, they having a special affinity for the toxin, and the only satisfactory explanation of the better action of anti-toxin by cerebral injection is based on these facts.

Given subcutaneously the anti-toxin only neutralizes the toxin already in the blood without affecting that in the nerve tissue and brain cells. Given direct into the cerebral tissue, the toxins in this tissue are neutralized directly.

We have had a single personal experience with tetanus anti-toxin (not Parke Davis') given hypodermatically in doses of ten c. c. every four hours for five days without the slightest effect. The case was a well marked and a severe one, dysphagia being especially severe. After this time we began the use of 4 per cent. carbolic acid injections every six hours, thirty c. c. being eventually given for each injection. Marked amelioration in the spasms including the dysphagia and locked jaws took place shortly after the urine showed evidence of carboluria. The acid was continued for several days, and while the urine showed considerable blood microscopically there were no other untoward symptoms. Within three days the spasms had almost completely subsided, the mouth was well opened and with very little difficulty, dysphagia was very slight, and only stiffness of the neck and back remained. Just at this time the patient was taken with a severe chill, pain in the stomach, and

vomiting, high fever, unconsciousness and death within twelve hours. The blood showed typical estivo-autumnal infection.

Carbolic acid hypodermatically has been found of value by many competent veterinarians in the treatment of tetanus, and many cures have been reported in man by Wood and others. It certainly should be tried in these almost hopeless cases, and if amelioration in the symptoms does not quickly follow its use, the *dernier ressort*, the cerebral injection of antitoxin, should be tried.] M. G.

Methylene Blue in Malaria.—In certain individuals the administration of quinin gives rise to unpleasant symptoms, says J. W. P. Smithwick in the February number of *Merck's Archives*. The untoward results have caused investigators to search for some substitute for quinin. For several years certain physicians have been experimenting with methylene blue, and have found it to possess very decided antimalarial properties. The medicinal preparation is a simple hydrochlorate of tetramethylthionin and is free from arsenic and zinc. It is usually administered in two-grain doses six times a day, in the form of capsules or pills. It will appear in the urine about an hour afterward, making it intensely blue. It acts as a diuretic, which is a valuable consideration where there is a tendency to hematuric complication.

A table of 50 cases of different types of malaria accompanies the article. Of these there were 24 cases of quotidian, 4 of tertian, 3 of quartan, 5 of estivo-autumnal, 3 of hemorrhagic, and one of double quotidian malarial fever. All but 7 recovered; 3 of these refused to take methylene blue after the first day, and the remaining 4 were in a bad physical condition, their deaths resulting from organic disease. The remedy has a twofold effect in the hemorrhagic type of malarial fever—that of a parasiticide and a diuretic. A relapse in one instance responded to the treatment, in this respect differing from the usual results of quinin administered under the same condition. The treatment was continued ten days after the last chill. He concludes that the cases need not be selected on account of idiosyncrasies, as the methylene blue produces no bad effects if administered intelligently; he believes it to be a perfect substitute for quinin. It is of especial value in the malaria occurring during pregnancy, as it has no oxytoxic effect, and increases elimination by the kidneys.—*Journal Amer. Med. Assoc.*

The Significance of Earache in Children.— T. H. Halstead (*Medical News*, March 17, 1900) concludes as follows:

1. Earache in children is usually caused by acute inflammation of the middle ear, suppurative, or catarrhal.

2. Infants and young children may have suppuration in the middle ear without giving satisfactory evidence of pain, or without rupture of the drum membrane.

3. In the absence of other known cause of pain, from which a child is evidently suffering, the first cause to be thought of should be acute otitis media, and this calls for an examination of the drum membrane.

4. It has been shown by examination of the middle ear during life and post-mortem, that purulent otitis media is nearly always present in acute infectious diseases of the gastro-intestinal and respiratory tracts in young children, especially in gastro-enteritis and broncho-pneumonia, to which disease it probably stands in a causative relation.

5. The cause of death in many acute and chronic infectious diseases, in meningitis and in the exanthemata is the result of unrecognized and untreated abscess of the middle ear.

6. Repeated earaches in children are, ordinarily, but a sign of acute exacerbations of a chronic otitis media resulting from adenoids.

7. In adult life, so called, catarrhal or progressive deafness is often but a final stage of the otitis media, which had its beginning in early childhood, when it was due to adenoids and practically curable.

The Organization of Aseptic Operation—Some of the Causes of Failure.—Lockwood, (*British Medical Journal*, Feb. 24, 1900) in speaking of aseptic operations, gives the following method for cleansing the hands of the operator and the skin of the patient: 1, shave when necessary; 2, thorough washing with soap and water, and in case of hands trimming the nails close; 3, with ether, benzine or turpentine remove all the remaining fat and grease; 4, saturate for at least two minutes with a 1-500 solution of biniodid of mercury in methylated spirits. As to suture-material, he prefers silk and silkwormgut in ordinary aseptic cases. Sometimes, as in litigating septic stumps, or in circumcision in children, catgut is preferable. The catgut is prepared by washing with soap and

water, and then soaking in ether until free from grease, and finally it is allowed to stand in a 1-250 watery solution of the biniodid of mercury, at least 72 hours. The biniodid of mercury is of more value than sublimate because it does not coagulate albumin and is less irritating.—*Phila. Med. Jour.*

Selection of Anesthetic in Surgery.—John A. Wyeth (*Journal of the American Medical Association*, March 24, 1900) says:

"In the first ten years of my practice I employed ether exclusively. I observed, not only the great irritation which the vapor of ether caused to the respiratory tract, but that in a certain proportion of cases, especially in alcoholic subjects, it was extremely difficult to secure a profound narcosis without inducing a threatening condition of asphyxia. Such annoyance as the churning of mucus into froth, which filled the pharynx and nasal cavities and occasionally drifted into the larynx and threatened the patient with asphyxia, were entirely absent in chloroform narcosis, and to the comfort both to the patient and the operator obtained in this manner, encouraged me to the more frequent employment of this agent. At present, in about 75 per cent. of my operations, I employ chloroform, either wholly or at some stage of the narcosis. In using it I invariably inject beneath the skin 1-4 grain of morphia with 1-150 grain of atropia, about fifteen minutes before the anesthesia is commenced. Their employment is based on what I believe to be a fact, that chloroform is dangerous chiefly to the heart, and that it is in the early stages of its administration that its danger is imminent. Chloroform should be administered with very great care, and one not thoroughly trained in its use should not administer it or permit it to be employed.

"I prefer the Esmarch screen, and administer chloroform very carefully, keeping the finger on the pulse all the time, and watching the pupil to notice any sudden change or dilatation. If the patient gradually gives way to the effect of the anesthetic, and the pulse holds good without any break or interruption of its rhythm, I am satisfied that the chloroform is having no unfavorable effect. The pulse may be rapid, 100 or 120 to the minute; it may be slow enough to register only 50 or 60 in the minute, but these variations are not suggestive of serious danger so long as the heart beats regularly. If it begins to break off and a beat is lost here and there, or if two

or three successive beats fall off in force and fullness and then rise again in volume, it is a signal of alarm which I always respect, and I then remove the screen and wait a few moments to see what the heart will do. If it steadies up with the removal of the anesthetic, I accept the inference that the slight interruption in the heart's rhythm is due to nausea, and continue with the anesthetic. But should there with this condition occur sudden pallor of the face, especially marked about the lips, I remove the chloroform at once and immediately cause the head and chest to be lowered by lifting the patient's lower extremities in the air, or by elevating my operating table in the Trendelenburg posture. If I am satisfied that the heart is showing any resentment to the effect of chloroform, ether is at once substituted, and should the patient continue to do well under ether, the operation may be concluded with this form of narcosis. However, when there has been only a suggestion of trouble from chloroform, and ether has been substituted for a few minutes, if there are kidney or other lesions which contraindicate the use of the latter, I return to chloroform, always, however, with increased precaution in noticing its action on the heart. Another usually alarming symptom of a too profound effect from chloroform is when the pupil is found suddenly and widely dilated, and I always desist from chloroform narcosis when this is observed.

"It is not proper in my opinion to endeavor to bring the patient rapidly under the influence of chloroform. The free admixture of air with the vapor, accustoming the nerve centers and the heart to the presence of this agent in the blood, is essential to safety. When ether is employed I always use it with the Ormsby inhaler, or some form of apparatus which does not permit the passage of the atmosphere over the ether vapor, and thence directly into the respiratory tract. The Allis instrument or any other form of inhaler is extremely objectionable, in my opinion, for the reason that the passage of the atmosphere over the ether vapor lowers the temperature of the inspired air very considerably, and carries this cold vapor into the respiratory tract, often producing severe irritation, and sometimes fatal inflammatory reaction. Moreover, the use of the closed apparatus, which mixes the air with the ether vapor, with which warm air is carried back into the lungs, produces a modified form of asphyxia and makes narcosis possible with a smaller quantity of ether carried into the blood than is possible with the open inhaler,

which permits an unlimited supply of oxygen into the lungs. This modified form of asphyxia is perfectly free from danger, can be controlled with great ease by the anesthetizer, and when it becomes necessary to increase the oxygen in the blood, the simple tilting of the inhaler to one side permits a sufficient quantity of fresh air to pass into the respiratory organs without permitting it to pass over the ether vapor. It is a well known fact that the elimination of ether vapor from the blood through the kidneys is the cause of very considerable irritation of these organs, and the larger the volume of ether in the blood the greater the volume of elimination by the kidneys. It is clear that the small quantity of ether necessary in the use of the closed inhaler in part removes this danger to the kidneys.

"In the hands of a tyro ether is safer than chloroform, and this without regard to the condition of the patient; but in the hands of an experienced operator, one who has studied his case carefully, and satisfies himself that the conditions justify the use of chloroform, this agent is practically without danger. I prefer to use chloroform in all cases where there are pathologic changes in the kidneys, and in which heart lesions are absent. When the lungs are seriously involved, as in tuberculosis, gummatous tumors, or any form of pulmonary inflammation, or in pleuritis in which there does not exist an effusion sufficient to interfere with the heart's action by compression, chloroform is in general preferable. When, however, in any way the heart has been crippled, ether is the safer. In general, in all operations within the abdominal cavity chloroform is preferable, for the reason that vomiting is less apt to occur during, as well as after the operation. As intimated above, however, when there is any heart lesion, even in abdominal surgery it is better to employ ether than threaten this crippled organ with chloroform. I am especially afraid of chloroform in patients who have had repeated attacks of rheumatism. In that class of patients known as "chronic alcoholics", chloroform is preferable, by reason of the difficulties met with in producing profound narcosis with ether.

In children, ether is in general the safer anesthetic, but a child of 10 years, on whom four days earlier an amputation had been done under chloroform without the suggestion of danger, while the wound was being dressed, and while chloroform was again being administered by the same physician, and with the same pre-

cautions, died with heart failure when not more than a dram of the agent had been employed, and before complete narcosis. Two other cases of chloroform anesthesia in children, in the hands of an experienced operator occurred to my knowledge, and if I know personally of three such instances, many others must have occurred. Chloroform is especially dangerous in children who have been weakened by inherited or acquired dyscrasia, or from improper nourishment, and great care should be taken to prevent too rapid administration of this agent, when, as is frequently the case, the little patient begins to struggle and make rapid and deep inspiratory efforts. In children over 12 years of age, well nourished, with no serious lesions of the kidneys or respiratory apparatus, chloroform is, in my opinion, as safe as ether."

Indications for and Method of Operating Upon the Middle Turbinated Bone.—John P. Davidson (*Virginia Med. Semi-Monthly*, March 9, 1900) says that:

"The indications which cause a demand for operative procedures upon the middle turbinated bone may be briefly summarized as follows:

1. For a large and well-defined class of cases suffering from nasal obstruction.

2. To remove an etiologic factor preparatory to, and for the further treatment of naso-pharyngitis, and chronic laryngitis.

3. For the relief obtained in certain cases of chronic catarrhal otitis media.

4. For the beneficial effects procured in cases suffering from reflex nervous symptoms, either accompanied or unaccompanied by asthma or hay fever.

Of the different methods used to remove a portion of the middle turbinate, my preference is decidedly for the cold wire snare. The snare which is the most desirable to me is the old Sajous slightly modified. The change made is a very much larger thumb screw, thereby facilitating turning, and, second, two holes are made in the end to contain the ends of the wire. This very greatly facilitates threading by putting one end of the wire through the hole farthest from the end and screwing it down until this passes within the shaft, when the remaining end of the wire may be passed into the distal opening, after which the excess may be cut with the wire scissors.

The next question is that of the most desirable local anesthetic. Certainly cocain secures for us the most profound anesthesia, but it greatly exsanguinates the soft tissue covering the bone, and, therefore, makes grasping it with the snare far more difficult. The shrinking of the lower turbinate by the action of cocain is, of course, desirable, since it produces a much larger cavity in the region of the lower turbinate, and thereby facilitates the manipulation of the snare. Recently I have discontinued the use of cocain and have been using extract supra-renal capsule and holocain. After having made an application of an aqueous solution of supra-renal extract of the lower turbinate and inferior meatus, we secure as much shrinkage of the mucous membrane as it is possible to obtain from any known agent. After having applied the supra-renal extract, we can effect satisfactory anesthesia of the middle turbinate by the use of holocain, which does not exsanguinate this body as cocain does. While holocain is quicker in its action than cocain, it is less profound in its effect, though my experience with it has been confined to weaker solutions than that of cocain, which we ordinarily employ. Not being as familiar with the constitutional manifestations of holocain as with those of cocain has prompted me to use the weaker solution, and 2 per cent. has been the strongest application I have employed so far. By using the methods of anesthetizing just described, it is possible to remove portions of the offending turbinal, which it is impossible to do with the snare under cocain anesthesia. When the turbinate is enlarged throughout its extent, it is not possible to surround it at one grasp of the snare. Under such circumstances it is most practicable to remove the posterior extremity first, and a second attempt may be made for the anterior portion. It is usually advisable, however, to leave the second portion for a subsequent sitting. Snaring the middle turbinate cannot be regarded as an easy operation, and occasionally we find it impossible to accomplish it. In such cases, the biting forceps, devised by Lester, are invaluable. The wound is not left as smooth as it is from the cold snare, and, furthermore, it is sometimes necessary to make several 'bites' before we remove it sufficiently.

Usually, the hemorrhage ceases in a few minutes, except a slight tinge to the nasal secretions. When the hemorrhage is slightly excessive, it is checked by a small pledget of cotton packed against

the wound. Very rarely it is necessary to plug the nose tightly with iodoform or some antiseptic gauze, which must be removed on the following day, when it may or may not require a second packing. Secondary hemorrhage occasionally occurs, which demands the same management as does the primary bleeding.

The subsequent treatment consists of cleanliness, secured by some antiseptic spraying solution, to be used by the patient. Infection has occasionally occurred, but its origin has practically always been traced to the lack of proper care. I have not seen any unfortunate complication result from infection other than a muco-purulent discharge, accompanied by a certain degree of reaction in the region of the wound. My method of treating this complication is irrigation with a warm antiseptic solution through the opposite nostril. I never remove both bones at the same sitting, but wait for the reaction produced by the first to subside before attacking the second."

Some Observations in the Ear Clinics of London, Berlin and Paris.—Briggs (Correspondence *Occidental Medical Times*, January, 1900) makes the following interesting observation on the subject of mastoid disease:

"I noticed little new in the treatment of diseases of the ear in my visits to the various clinics with the exception of the indications for, and the treatment of mastoid disease. In acute cases the treatment is very much the same by all experienced operators. The difference mainly consists in the thoroughness with which the operator removes the diseased tissue, and continues the investigation to the sinus or brain in cases indicating disease of these parts.

The rules for performing the radical operation in chronic suppuration of the middle ear are not so clearly defined nor have the various operators come to any common understanding as to the indications for it. Luc, of Paris, and many other otologists believe that the radical operation should be done in cases of middle ear suppuration which do not recover after a month's faithful treatment. This rule, however, is far from being universally accepted, and the question still remains open for discussion.

Observing physicians can no longer doubt that chronic suppuration in the middle ear is a constant menace to the life of the patient. The great importance of this subject has not been long

understood by specialists, and many practitioners still consider ear discharges of little significance. The family physician occasionally discovers the connection between a chronic ear discharge and brain disease when it is perhaps too late to save the patient by an operation. Every physician of experience will remember such cases. The most progressive men of today advocate operating upon all chronic suppurations of the middle ear before such unfortunate extension can take place.

Jansen, of Berlin, does not lay down any specific time limit when the radical operation should be undertaken, but bases his decision upon the conditions found in the ear and neighboring tissues. He has undoubtedly had more experience during the past ten years with this class of cases than any other operator. Dr. Jansen, being a modest man, does not state how many mastoid operations he has done, but those in a position to know informed me that he had performed more than three thousand during the past ten years. I have seen him do three in a single day, and my observation leads me to conclude that he does this operation with as great a degree of perfection as it is possible to attain.

Jansen has, I believe, abandoned the Stacke operation altogether. He begins by making the incision close to the ear, and then clearing the bone of periosteum from the meatus well back on the mastoid. The chiseling is begun just below the linea temporalis, using broad chisels at first and changing to narrower ones as he goes deeper into the bone. The bone and cells are carefully removed till the antrum is reached. All disease tissues are removed, using care not to injure the sinus or other important parts. The posterior wall of the bony meatus is then taken away uniting the antrum, the attic and the middle ear cavities. The remaining parts of the drum membrane and ossicles and any granulation tissue in these cavities is also carefully removed. The lining membrane of any cholesteatoma-producing cavity is thoroughly removed. This is best accomplished with a small burr driven by an electric motor. This instrument is also used to smooth off any uneven places in the bone cavity. After the bleeding is checked the Thiersch skin grafts taken from the previously prepared arm or leg are placed in the cavity and covered with a small piece of guttapercha tissue over which is a piece of lint lightly spread with simple ointment held in place with small pieces of plain gauze.

The skin and cartilage of the meatus is now divided by two incisions so as to allow the flap to be moved back into the cavity. The incisions are extended internally to enlarge the meatus and facilitate future care of the wound cavity. The flap of the meatus is now packed against the posterior wall of the bony cavity on that portion unoccupied by the Thiersch grafts, and the external wound closed by sutures.

Perfect asepsis is maintained throughout all steps of the operation. Iodoform gauze is used to pack the wound cavity with the exception of the plain gauze that holds the skin grafts in place. In certain cases the extent and condition of the wound will not permit of immediate closure of the external opening. In such cases a secondary operation is done when the wound cavity has become covered with healthy epithelium. The use of Thiersch skin grafts is a decided advance over the method in general use of allowing the wound to heal by granulation. I have seen a number of cases which healed within two weeks. When the wound is left to granulate months are often required before the process of healing is complete.

The only operation I saw performed in London for the cure of chronic suppuration was that of Stacke. Luc, of Paris, also prefers that method. My own conviction, however, is in favor of the operations with skin grafts as performed by Jansen. The diseased tissue is much more thoroughly destroyed and the likelihood of future trouble is, I believe, much less than after the Stacke operation.

Since my visit to the European clinics seven years ago the radical operation has been established on a solid foundation, and the frequency with which it is at present performed attests to the fact that it is comparatively free from danger and that the patient's safety and comfort is greatly promoted thereby. There are many men who protest that mastoid operations are done too often by certain surgeons. It is no doubt true that some cases are operated upon that would either recover or that would continue indefinitely without serious results. But I think the time will soon come when it will be considered quite as unjustifiable to allow an ear to suppurate indefinitely as it is, at present, to permit a case of chronic appendicitis with probable suppuration, to go on without surgical treatment."

What Precautions Shall We Take to Avoid Leaving Foreign Bodies in the Abdomen after Operations?—Howard Kelly (*N. Y. Med. Jour.*, March 24, 1900) relates the history of five cases observed in his own practice, where sponges, and once an artery forceps were left in the abdominal cavity after an operation, and concluding that the danger is a real one in the hands of the most experienced, formulates the following rules for avoiding such an accident:

1. In the first place, always commence with a definite number of pieces. I begin my operations, for example, with seven marine sponges and nine pieces of gauze, an ample provision for the average case.

2. Write down upon a slate or a piece of paper the number of sponges and pieces of gauze in use.

3. If more are added it is the duty of the assistant to instruct the nurse to write them down at once and to receive from her a statement as to how many she has recorded.

4. I would, with Boldt, urge the entire abandonment of small pieces of gauze and small sponges.

5. Avoid packing of gauze up in the abdomen out of sight.

6. The use of a bit of tape, as recommended by Boldt, attached to the corner of the gauze and left hanging out of the wound with a forceps clasped on the end makes a safe tracer, although, this too, has failed as an absolute safeguard.

7. If marine sponges are used, they may be inclosed in a loose gauze bag, with a tracer similarly attached; sponges held in long forceps do not need a tracer.

8. The operator should put the simple questions, at the close of the operation: how many pieces of gauze are called for, and how many sponges are called for? These questions should be answered without circumlocution or explanation by the simple, direct statement of the numbers wanted. In order to keep my assistants on the alert, and as a means of training them to be extremely careful, I occasionally hold back a sponge or a piece of gauze, and do not give it up until they insist that it is wanted.

9. Never under any circumstances should the count be muddled by cutting the gauze or dividing a sponge.

10. It is my practice to make two people responsible for the number of pieces used, as well as for their production at the end of the operation; these are the assistant who handles the sponges,

and the nurse. In some clinics, where fewer assistants are used, it will be necessary to place all the responsibility on one head, either nurse or first assistant.

11. The discarded gauze or sponges must always be thrown into a receptacle, and never, under any circumstances, mixed with soiled dressings, towels, or sheets, or, worst of all, carried out of the room during the progress of the operation. I have had made, for the purpose of facilitating the counting of these articles, a simple wire frame. The discarded gauze pads are thrown over the horizontal bars, and the sponges are spiked on the sharp pins. In this way soiled articles collected in a definite place can be counted without handling them.

12. In addition to all the precautions noted, the surgeon must exercise his vigilance in taking an exact note of everything that is put in the abdomen, and it may be of service to memory to state aloud, "one sponge introduced into the abdomen," "two pieces are now in the abdomen," etc.

13. An examination should be made in all cases to see by actual inspection and by touch that nothing has been left behind. Such an examination will not, of course, be pushed to an extreme unless there is a missing article to be discovered.

Experimental Researches on the Effects of Different Anesthetics on the Kidneys.—Kemp has contributed an exhaustive research upon this subject to the *N. Y. Medical Journal* of November and December, 1899. In concluding his report he says:

1. Examine the urine carefully and measure same for twenty-four or forty-eight hours before operation; the urea, indican and chlorides should be noted.

2. Catheterize the patient immediately before the anesthetic is started. This eliminates residual urine from any cause whatever. He believes the nervous element may prevent the complete voiding of the urine. Examine this specimen.

3. Catheterize the patient immediately at the close of the anesthesia, noting time and nature of operation, quantity of anesthetic, nature and method of administration, and how borne by patient; measure the urine, and you have the absolute results of the anesthesia. Test urine for specific gravity and quantity secreted, also for albumin, sugar, casts, etc., and also for indican, chlorides, urea, etc.

Specific gravity and quantity have been noted at Johns Hopkins Hospital.

The following interesting fact was noted: Indican was increased very markedly by ether, and also was produced markedly if absent before anesthesia; and if present in a small quantity this was considerably increased. The same result was produced by chloroform, but was less in quantity than with ether. With nitrous oxide indican was produced or increased, but also less than with ether.

Kemp was able to make these tests on twelve cases of ether narcosis, three of chloroform and two of nitrous oxide and oxygen. The comparative effect between chloroform and nitrous oxide was difficult to judge of on account of the few cases, though nitrous oxide seemed to produce a trifle less than the chloroform. As regards albumin, following the method of catheterism as above described in twelve cases of ether, he found a trace of albumin in three instances where there was none previous to operation, and in one case a slight increase where it previously existed; no renal complications, however, followed, so far as he could learn. With chloroform (three cases) he found no change. In two cases of nitrous oxide there was no change in the urine after operation; in one case there was no albumin previous to it.

In the other case of nitrous oxide and oxygen there was a trace of albumin before operation and a few casts. After operation the albumin disappeared, the number of casts diminished and the patient passed seventy-five ounces of urine in the first twenty-four hours after operation, against fifty-two ounces twenty-four hours before. There was a special reason for this, namely, the slight changes in the urine. A hypodermoclysis of normal saline solution, six ounces, was given just before the anesthetic was removed. This procedure in such conditions seems of value, as it is simple but efficacious. An enema is apt to be voided or objected to by the patient. A convenient place is the lumbar region, between the crest of the ilium (posteriorly) and lower border of the ribs, gentle massage being employed. The patient had no renal complications. This method is to be employed when the question of renal (subsequent) complications might occur.

As Dawbarn does with "infusion to prevent shock" so should we with "hypodermoclysis" to minimize so far as possible the danger of renal complications due to the anesthetic in those cases

where disease of the kidneys already exists or is suspected. This rule should be applied to any anesthetic. The employment of that anesthetic least deleterious to the kidneys, with the addition of hypodermoclysis at the close of the operation, would seem a logical course to pursue.—*The Therapeutic Gazette*, March 11, 1900.

Use and Abuse of Poultices.—Owing to the lack of proper instructions to the patient in the use of poultices, says S. E. Earp in the *N. Y. Medical Journal*, February 2, much harm is often done. The majority of people are quite ignorant as to the purposes for which poultices are applied. He gives the following eight conditions under which they should be employed:

1. To relieve congestion.
2. To reduce inflammation.
3. To promote absorption, favor resolution, or hasten suppuration.
4. To diminish tension.
5. To soften incrustations.
6. To encourage tissue relaxation.
7. To stimulate healthy granulations.
8. To perform the office of a deodorant, and in a sense as an antiseptic.

Used improperly they may produce an anemia, flabby condition of the part, and consequently a lowering of the vitality, and possibly a necrosis of the tissues. A poultice applied after the evacuation of the pus is often a detriment.

The material, except that it should be usually unirritating, matters very little — the only consideration being its heat-retaining capacity. In pneumonia, peritonitis and other deep-seated inflammations the poultice should be large, to cover a surface equal to the organs, and reapplied often to get the effect of the heat. It should be covered with sheet rubber, oiled silk or oiled newspaper, and should not remain in contact when cold.

The poultice may be used as a medium where the therapeutic effects of certain absorbable disinfectants, counterirritant or anodyne remedies are required.

The charcoal poultice is used as a deodorant in foul ulcers or where there is gangrene, but it must be frequently replaced, as its

rapid absorption of gases soon renders it useless. When used, a layer of powdered charcoal should be sprinkled on the surface.

Linseed meal, which is popular because of its oleaginous nature, is prepared by adding two parts of meal in small quantities to five parts of boiling water.

Bread poultice may be prevented from drying quickly by adding marshmallow, glycerin or vaselin.

Suprarenal Therapy.—Bates (*The Medical News*, March 24, 1900) draws the following conclusions:

1. The aqueous extract of the suprarenal capsule when used locally is the most powerful astringent and hemostatic known.

2. By reason of its action on the heart, congestion of the mucous membrane and other tissues of the eye are relieved to a less degree by the internal administration.

3. Congestion of other organs in addition to the eye are relieved by the local and internal use of the extract.

4. The extract is useful in all forms of inflammation, and in inflammation in all parts of the body.

5. The suprarenal is the strongest known stimulant of the heart.

Finally, we may say that the reason why so little disturbance has followed the use of this powerful substitute for six years by so many observers, that we are using a material which is necessary to the normal function of the body, and I wish to repeat that within the limits of its sphere of activity no other substance can take its place.

Can the State Suppress Genito-Urinary Diseases?—Valentine (*Jour. A. M. A.*, March 3) says that the control of public prostitution, even if ideally carried out, can be but a small factor in the prevention of genito-urinary diseases, giving statistics showing where such laws had been almost ideally carried out. If a woman were examined and found uninfected on a Monday and has relation with an infected man on that day, she has had opportunities for infecting men for three days before she is re-examined on Thursday, and even then might succeed in getting another certificate to last until the following Monday. In addition there are generally more women who escape the vigilance of the police than come up for examination.

The only effectual method of such public safeguarding would be to make a microscopic examination after each coitus; the medical profession has no member so degraded as to spend his life at such work. Physiologically and psychologically, extra-matrimonial intercourse is not preventable, and physicians know that men who have suffered, even most intensely, from genito-urinary disease, expose themselves to a new infection, even long before they are cured. A case is cited where a man of high sensibilities and well educated had the misfortune from ignorance to infect his father with gonorrheal ophthalmia by using the bathtub before him. If he had known and understood the highly contagious character of the virus, this might have been prevented.

The inferences to be drawn from the paper are:

1. Sufficient of the physiology and pathology of the genito-urinary apparatus should be taught, in institutions for higher education, to convey to students the dangers of genito-urinary diseases to themselves and to others.

2. Similar instructions should be given in schools attended by boys at the age of puberty.

3. No man who has ever had gonorrhea should be allowed to marry until it is proved by a physician that he cannot infect his wife.

4. Regular physicians should be elected, by their associates, to deliver evening lectures to the public on genito-urinary diseases.

5. Every father should be taught to warn his sons of the dangers of genito-urinary diseases. When from incompetency or delicacy the father cannot see or does not wish to do this, the family physician should discharge this duty.

6. Every medical society should elect its most competent member to write at least one article on the subject for laymen's comprehension, to be published under the auspices of the society.

Home and Asylum Treatment of Inebriety.—T. D. Crothers, (*Virginia Medical Semi-Monthly*, March 9, 1900) makes prominent the following facts:

"1. The treatment of inebriety extends back twenty centuries, and more, and the recognition as a disease is still more ancient.

2. Its prominence, and the increasing urgency for relief from medical men, demand a new study of the whole subject along a scientific line.

3. The inebriate is literally poisoned, and starved, and degenerate, and there is no mystery about his condition or the results of treatment.

4. The possibility of restoration and cure is established beyond question.

5. Gold and other specific cures are only the application of common remedies, which every physician could use with greater skill and success.

6. Every case can be restored, and many of them permanently cured, by the intelligent co-operation of the family and asylum physician. Both home and asylum treatment are invaluable.

7. The public treatment of pauper inebriates and the incurable classes will be carried on in workhouse hospitals, specially organized for this class. The treatment of those able to pay will be in special private hospitals, where the best means of science can be combined to meet the wants of each case.

8. The successful cure and prevention of inebriety is largely an unoccupied medical field, the solution of which opens up a new realm of practice, promising the greatest possibilities, which, in the near future, will be occupied."

Shock, and its Surgical Significance.—Rishmiller (*N. Y. Med. Jour.*, March 17, 1900) draws the following conclusions:

1. Sensory-nerve irritation, sufficiently powerful to produce exhaustion of the vaso-motor center, causes a reflex paralysis and consequently a dilatation of the vascular mechanism.

2. Children, and aged people with lax fibers, and those addicted to alcohol, bear a peculiar susceptibility to shock.

3. Hemorrhage is the most pronounced cause, particularly if venous, as then the equilibrium of the vaso-motor mechanism is too suddenly deranged.

4. Two distinct types are recognized: prostration with indifference and prostration with excitement.

5. Peritoneal absorption of septic material invariably terminates fatally through shock before evident manifestations of peritonitis have developed.

6. A sub-normal temperature, irregular pulse, superficial respiration, cold and anemic extremities and clammy perspiration contra-indicate an operation.

7. The severity of operation shock largely depends upon the length of time in the performance of the operation, and the duration and degree of the anesthesia.

8. Shock may to a large degree be prevented by any counter-irritation applied to the extremities.

9. Brandy per os, and morphin subcutaneously before operating, are imperative precautions toward prophylaxis.

10. The main treatment consists in stimulating the vascular system and to preserve the animal heat and supply artificial heat to the body.

11. In acute hemorrhage, or other excessive anemia, an infusion of normal saline solution is prudently indicated.

A Horological Nomenclature of Anal Fistulæ.—We have always objected to classifying versions of the uterus as of the first degree, of the second degree, etc., but we must admit the ingenuity of a scheme hit upon by the surgeons of St. Mark's Hospital, London, for designating the situation of the external opening of an anal fistula, as described by a correspondent of the *Presse Medicale* in a communication published in that journal for January 24th. The numerals that stand for the twelve hours are imagined to be arranged around the anus after the pattern of a dial, xii being situated in the perineal raphe, vi at the tip of the coccyx, and so on. By this plan a fistulous opening, lying a little to the right of the median line, and in front of the anus is tersely termed an 11 o'clock fistula; a 1 o'clock fistula opens at a corresponding point on the left side, and other hour-marks do duty in like manner. It must save a good deal of talk.—*N. Y. Medical Journal*, March 17, 1900.

The Louisiana State Board of Health, in conjunction with the Louisiana State Board of Medical Examiners, is arranging for a second registration of physicians in Louisiana. The purpose of this registration is to obtain entirely definite information, and to clear up certain ambiguities occasioned in the construction of the first enacted law.

BOOK REVIEWS.

Any medical book can be obtained through the Lancet at publisher's prices, postage free. Terms cash. The usual discounts are allowed.

Diseases of the Nose and Throat. By J. Price-Brown, M.B., L.R.C.P.E., Member of the College of Physicians and Surgeons of Ontario; Laryngologist to the Toronto Western Hospital; Laryngologist to the Protestant Orphans' Home; Fellow of the American Laryngological, Rhinological and Otological Society; Member of the British Medical Association, the Pan-American Medical Congress, the Canadian Medical Association, the Ontario Medical Association, etc., etc. Illustrated with 159 engravings, including 6 full-page color plates and 9 color cuts in the text, many of them original; 6¼ x 9¼ inches; pages xvi–470. Price, extra cloth, $3.50 net. The F. A. Davis Co., Publishers, 1914–16 Cherry street, Philadelphia.

This book is written especially for beginners in the subject, and for those who do not practice rhinology as a specialty, but are compelled to do some work in that line for geographic reasons. The style of the work keeps this purpose in mind, and is always brief, terse, and extremely clear. Theories are given but little room, the whole trend of the contents being practical. There is no room for literary references, and they would be out of place in this sort of a book. As commendable features, we note the use of the metric system throughout, and hope this will be a feature of all our books in a short time. A consideration of diphtheria is omitted, and this, we think, is to be commended, since nose and throat specialists do not treat diphtheria as a rule in many localities, and the subject is dealt with in textbooks of medicine. The cuts are well selected, those of instruments being profuse, but with the exception of some admirable colored plates of frozen sections of the head, the illustrations are very poorly executed. The adenoid pictures are those of Schadle, and are very instructive; we have long considered them the most information-giving with which we are acquainted. We are surprised to note the use of the accusative "aquam" habitually in the prescriptions, and would also refer to some important omissions from the subject of deflected septum, notably the Asch operation. On the whole the book is a worthy product of its conscientious author, and, bearing in mind its purpose, is to be highly recommended.

A Pocket Medical Dictionary. Giving the Pronunciation and Definition of the Principal Words used in Medicine and the Collateral Sciences, including very complete Tables of Clinical Eponymic Terms of the Arteries, Muscles, Nerves, Bacteria, Bacilli, Micrococci, Spirilla, and Thermometric Scales, and a Dose List of Drugs and their Preparations in both the English and Metric Systems of Weights and Measures. By Geo. M. Gould, A.M., M.D., Author of The Illustrated Medical Dictionary, The Student's Medical Dictionary; Editor of the Philadelphia Medical Journal; President, 1893–1894, of the American Academy of Medicine. Fourth edition, revised and enlarged; 30,000 words. P. Blakiston's Son & Company, Philadelphia, 1900. Price, $1.

We have had occasion to call attention several times to the utility of small books, and to none do our good opinions apply more than to the dictionaries. We can conceive of no more useful book to keep on one's desk, when its size permits, and this is true of this volume. The numerous tables it contains are especially valuable. Dr. Gould is probably the foremost medical philologist of the day, and while the scope of this work is not so great as that of his more pretentious dictionaries, it gives the correct spelling, pronunciation and definition of 30,000 medical terms. The low price, attractive press work and flexible leather covers are all advantages, and we certainly commend the book as a most useful and handy companion.

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BOOKS AND PAMPHLETS RECEIVED.

A Pocket Dictionary, giving the Pronunciation and Definition of the Principal Words Used in Medicine and the Collateral Sciences, including very complete tables of clinical eponymic terms of the arteries, muscles, nerves, bacteria, bacilli, micrococci, spirilla, and thermometric scales and a dose list of drugs and their preparations, in both the English and metric systems of weights and measures. By George M. Gould, A.M., M.D., author of "The Illustrated Medical Dictionary," "The Student's Medical Dictionary," editor of the *Philadelphia Medical Journal*, President 1893–94 American Academy of Medicine. Fourth edition, revised and enlarged. 30,000 words. P. Blakiston's Son & Co., Philadelphia, 1900.

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The International Textbook of Surgery, by American and British Authors. Edited by J. Collins Warren, M.D., LL.D., and A. Pearce Gould, M.S., F.R.C.S. Vol. II, Regional Surgery. With 471 illustrations in the text, and eight full page plates in colors. W. B. Saunders, Philadelphia. Price, cloth $5, half morocco $6. In two volumes.

Surgical Pathology and Therapeutics. By Jno. Collins Warren, M.D., LL.D. Illustrated. Second edition with appendix containing an enumeration of the scientific aids to surgical diagnosis, together with a series of sections on Regional Bacteriology. W. B. Saunders, Philadelphia. 1900. Cloth $5, half morocco $6.

The Diagnosis of Nervous Syphilis. By Chas. W. Burr, M.D., Philadelphia. (Reprinted from the *University Medical Magazine*, July, 1899.)

A Case of Cerebral Hemorrhagic Pachymeningitis with Pseudo-Bulbar Palsy. By Chas. W. Burr, M.D., and D. J. McCarty, M.D. (Reprinted from *Journal of Nervous and Mental Diseases*, Oct., 1899.)

Sterility and Pelvic Deformity. By Joseph Brown Cooks, M.D., New York, N. Y. (Reprinted from the *Medical and Surgical Monitor*, February, 1900.)

Some Casual Remarks on Prostitution and Veneral Diseases in Their Relation to the Public. By Isadore Dyer, of New Orleans. (Reprinted from the *Philadelphia Medical Journal*. Feb. 10, 1900.)

NEWS AND NOTES.

Dr. J. W. McDonald, of Jackson, Tenn., died of pneumonia on March 16th.

Dr. Chas. McBurney has resigned from the staff of Roosevelt Hospital, New York.

Dr. G. G. Buford is arranging for a very pleasant excursion party to the Paris Exposition.

Dr. Hunter Maguire, of Richmond, Va., has suffered a paralytic stroke, and his recovery is doubtful.

The newest disease of which we are advised affects those who ride in horseless carriages. It is termed "auto-mobilousness."

Examinations will be held during April to elect four resident physicians for the City Hospital, and one for St. Joseph's Hospital.

We desire to again acknowledge our indebtedness to the *Philadelphia Medical Journal* for many notes concerning events of interest to our profession.

Dr. Jay F. Schamberg has been elected Professor of Diseases of the Skin in the Philadelphia Polyclinic to succeed Dr. J. Abbott Cantrell, who has resigned.

The second annual meeting of the American Proctological Society will be held May 2 and 3, 1900, at Washington, D. C., President Dr. Jos. M. Mathews, of Louisville.

The resignation of Miss Thomsen as head nurse at the City Hospital is a source of much regret to the members of the staff, especially since the cause is ill health.

The Mississippi State Medical Association will hold its next annual meeting in Meridian, on April 18, 19 and 20. Dr. R. E. Jones, President: Dr. J. R. Tackett, Secretary.

Dr. M. B. Herman has been so unfortunate as to suffer an infected wound of the thumb, inflicted while operating. He has been incapacitated from work for two or three weeks.

Dr. Marcus Haase, the efficient secretary of the Memphis Board of Health, has been tendered an appointment in the Marine Hospital Service. He will be stationed at port of Cortez, Spanish Honduras.

No essay having been submitted for the Samuel D. Gross prize of the Philadelphia Academy of Surgery which the trustees deemed worthy of the prize, amounting to $1000, they announce that the award will not be made until October 1, 1901.

Dr. S. S. Terrill of this city was married in February to Mrs. Decie Burge at Sardis, Miss. The wedding was a surprise to the doctor's associates, but they recovered sufficiently to extend their congratulations, in which the Lancet sincerely joins.

We take pleasure in announcing the marriage of Dr. Thomas J. Crofford, of this city, to Miss Ellie Barr, of Gallatin, Tenn. The wedding occurred on March 5th, at Gallatin, and Dr. and Mrs. Crofford are now "at home" at the Peabody Hotel, this city.

The Mississippi State Legislature passed a bill imposing the following annual graduated tax upon physicians practicing in that State: Physicians practicing in towns of 3000 or more inhabitants, $10; in towns of less than 3000, $5; in country districts, $2.50.

W. Granville Smith, the artist who painted the picture of "The Country Doctor" now owned by the Arlington Chemical Co., is preparing a special art reproduction of the picture, in colors. The edition will be limited to 250 signed copies. The work is to be done by Goupil & Co., of Paris.

We quote the following from the *Philadelphia Medical Journal:*

"Well Done! The quack medical men try hard to get their advertisements in the *Farm Journal.* Last month we were obliged to turn down a thousand dollar order. That new press shall not be smirched in that way.—*The Farm Journal.*"

Owing to the Resignation of Dr. John Ashhurst, Jr., the John Rhea Barton Professorship of Surgery in the Department of Medicine of the University of Pennsylvania will be vacant August 31, 1900. Individuals desiring to be considered as candidates for the impending vacancy may send notice of such desire to the Rev. Jesse Y. Burk, Secretary of the Board of Trustees, University of Pennsylvania, 400 Chestnut St., Philadelphia, April 7, 1900.

We have received the first copy of the *French Index Medicus*, (Bibliographia Medica), edited by Marcel Baudoin. If the succeeding numbers equal the first, the profession is again in possession of this valuable work. The subscription is fifty francs ($10.00) a year. Address 93 Boulevard Ste. Germain, Paris. The *Index* appears monthly.

A Special Course in Ophthalmology for medical practitioners will be held in St. Louis, beginning April 16, 1900, and continuing six weeks. It will consist of didactic lectures, recitations, clinical lectures, and laboratory work. The instruction will be given by Dr. Jas. Moores Ball, assisted by Dr. E. C. Renaud, and a corps of special lecturers.

The West Tennessee Medical and Surgical Association will meet at Jackson, May 17–18, 1900. You are cordially invited to be present, and contribute a paper on a subject of your own choice. This association has a substantial growth, both in members and interest, each year, and to the medical man living in this section is probably the best medical society he can attend. The papers contributed are eminently practical and of much interest to the general practitioner.

The following have been re-elected as members of the Staff of the City Hospital:

Physician—Dr. S. J. Cooper.
Surgeon—Dr. John Maury.
Gynecologist—Dr. S. E. Rice.
Obstetrician—Dr. Alex. Erskine.
Ophthalmologist—Dr. E. C. Ellett.

The following were retired by virtue of the new ordinance, which reduced the size of the staff:

Physicians—Drs. E. E. Haynes and J. H. Reilly.
Surgeons—Drs. M. B. Herman and F. D. Smythe.

The next course of ten lectures instituted by the late Professor Thomas Dent Mutter, M.D., LL.D., on some "Point or Points in Surgical Pathology," will be delivered in the winter of 1902–1903 before the College of Physicians of Philadelphia. The compensation is $600. The appointment is open to the profession at large. Applications stating in full subjects of proposed lectures, must be made

before October 1, 1900, to the committee on the Mutter Museum. John H. Brinton, M.D., Chairman. The lectures for 1899–1900 will be delivered in March and April, 1900, by Dr. Jno. B. Roberts, of Philadelphia, the subjects covered being the surgical and artistic anatomy and cosmetic surgery of the face, including the eyes, ears, nose, mouth, etc.

PRELIMINARY PROGRAM OF THE MEDICAL SOCIETY OF THE STATE OF TENNESSEE.—To be held at Knoxville, April 10, 11, 12, 1900.

PAPERS.

1. Heredity, the Presidential Address—Dr. D. E. Nelson, Chattanooga.
2. Chronic Non-Suppurative Inflammation of the Middle Ear—Dr. B. F. Young, Knoxville.
3. Dystocia, Due to Diseases of the Mother—Dr. R. J. McFall, Cumberland City.
4. Alcohol in the Practice of Medicine—Dr. I. A. McSwain, Paris.
5. Albuminuria—Dr. Frank B. Reagor, Shelbyville.
6. Dangers and Treatment of Abortion—Dr. J. S. Nowlin, Shelbyville.
7. Cystitis—Dr. J. B. Murfree, Jr., Murfreesboro.
8. Cæsarean Section, with Report of a Case—Dr. M. C. McCannon, Nashville.
9. Paper—Dr. W. G. Bogart, Chattanooga.
10. Pneumonia in Children—Dr. D. R. Neil, Nashville.
11. The Much-Abused Mosquito—Dr. J. T. Griffin, Tiptonville.
12. Observations in Thought Pathology—Dr. G. P. Edwards, Nashville.
13. The Practice of Medicine as a Business—Dr. J. R. Jump, Lenoir City.
14. Fistula in Ano—Dr. J. T. Graham, Booneville.
15. Treatment of Urethral Stricture—Dr. W. F. Glenn, Nashville.
16. The Correction of Certain Deformities of the Nasal Septum—Dr. Richmond McKinney, Memphis.
17. Sanitary Thoughts—Dr. E. H. Jones, Murfreesboro.
18. A Case of Vesical Calculi—Dr. A. B. Ramsey, McMinnville.
19. Some Points in Pelvic Inflammation—Dr. T. J. Crofford, Memphis.
20. Three Cases of Atypic Pneumonia—Dr. H. C. Chance, Tazewell.
21. A Warning in Regard to Vaccination. Some Companions—Dr. F. J. Runyon, Clarksville.
22. Work Develops; Worry Deteriorates the Brain—Dr. G. W. Drake, Hollins, Va.
23. Salpingo-Oophorectomy, with Report of Three Cases—Dr. S. B. Fowler, Gainesboro.
24. E. J. Senn's Amputation of the Breast for Carcinoma—Dr. T. J. Happel, Trenton.
25. Salient Points in Appendix Operations—Dr. R. E. Fort, Nashville.
26. A Plea for the Differentiation of Continued Fevers—Dr. J. D. Plunket, Nashville.
27. Paper—Dr. S. S. Crockett, Nashville.
28. The Anatomy and Pathology of the Rectal Valves—Dr. A. B. Cook, Nashville.
29. The New Treatment of Obstipation—Dr. Thomas Charles Martin, Cleveland, O.
30. The Perfection of the Technics in Aseptic Surgery—Dr. W. D. Haggard, Jr., Nashville.

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CLINICAL NOTES.

The steamships *City of Rome* and *State of Nebraska* have been chartered to leave New York on June 30, 1900, especially for physicians, their families and friends who desire to visit the Paris Exposition and other parts of Europe. Trip to last thirty-two days. Rates low and first-class passage. The physicians of the West are going in a body, and the physicians of Alabama, Mississippi, Louisiana, Arkansas, Tennessee and Indian Territory have been invited to go with them.

For full particulars, address G. G. Buford, M.D., Memphis, Tenn.

Protonuclein in Diphtheria.—

Case 780. Dr. —— writes: Have used Protonuclein Tablets in 294 cases of diphtheria, in conjunction with antitoxin, and have never lost a case.

Iodoform and its Congeners.—In discussing the various substitutes for iodoform, E. S. Yonge, M.D., C.M., physician at the Manchester Hospital for Consumption, Manchester, England (*Medical Brief*, February, 1900), says that Europhen is one of the best substitutes for iodoform. Without being devoid of scent, it does not possess a sledge-hammer odor like its congener. It is non-toxic, adheres well to a wound, does not cake, and, owing to its lightness, a given weight, as compared with iodoform, will cover a surface five times the area of the latter. The general opinion is, that this drug can be used in all cases that are benefited by the application of iodoform. In venereal ulcers it acts well, and in these cases should certainly replace iodoform. In summing up the relative advantages of the substitutes of iodoform as compared with that drug, the author states that Europhen is probably the most efficient substitute, as far as antiseptic action is concerned.

Congestive Dysmenorrhea.—

℞ Neurosine (Dios),
Dioviburnia (Dios), āā ʒiv.

M. Sig.: Teaspoonful three times a day.

Protonuclein in Quinsy.—

Case 757. Dr. —— writes: Protonuclein will abort quinsy every time. I have several patients who were subject to quinsy on the least provocation, who report that the Protonuclein Tablets never fail.

Trophonine

a palatable and nutritious liquid food, contains the nutritive elements of beef, wheat-gluten, and nucleoalbumins, so prepared as to be readily absorbed and aid almost immediately in the process of reconstruction. It furnishes the sick with the largest possible supply of nourishment and with the minimum tax on the digestive organs.

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by increasing the number of Leucocytes, destroys toxic germs, increases the inherent resistance to disease, quickens glandular activity, arouses the nutritive forces, gives tone to the system, and stimulates cell-life throughout the organism.

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is the only perfect digestant. It digests every variety of food. In physiological activity it presents the active and mother ferments of the entire group of digestive organs. It aids digestion by furnishing an additional supply of protoplasmic material out of which active ferments are elaborated, and perfects the process by increasing cellular activity.

FORMULA.—Take 1000 each of SALIVARY, PEPTIC, PANCREATIC, LIEBERKUHN'S, and BRUNNER'S glands, and the ALCOHOLIC EXTRACTS OF 1000 SPLEENS AND LIVERS, so any quantity contains a proportionate quantity of the enzyme principles of the whole series of digestive organs. To one part in powdered form and slightly benzoated and separated mechanically as above, add 1.5 parts of powdered sugar, 1.5 parts of powdered milk-sugar, .16 parts of citric acid.

Samples and literature on request.

Reed & Carnrick, 42-46 Germania Ave., Jersey City, N. J.

Sanmetto in Chronic Orchitis.—J. A. Stothart, M.D., Savannah, Ga., reports the following case: During November, 1898, a Greek fruit vender called at my office, suffering with chronic orchitis. The patient stated that the first attack occurred four years prior to this time. During the four years there had never been more than two and a half months between the attacks. He had been under treatment most of this time, and several times in the hospitals, and had been discharged as cured by several physicians. The testicle had almost arrived at the condition of ossification, but at no time had there been any pus formation. I prescribed Sanmetto and directed that the treatment be continued for two or three months. My treatment was carried out to the letter, and there has never been any return of the trouble since beginning the use of Sanmetto. I have used Sanmetto in other urethral troubles with very satisfactory results.

Headache, Hemicrania, Neuralgia.—

℞ Neurosine (Dios), ʒ viij.

M. Sig.: Dessertspoonful three to five times a day.

Pepsin is undoubtedly one of the most valuable digestive agents of our materia medica, provided a good article is used. Robinson's Lime Juice and Pepsin, and Arom. Fluid Pepsin (see page 17 this number) we can recommend as possessing merit of high order. The fact that the manufacturers of these palatable preparations use the purest and best pepsin, and that every lot made by them is carefully tested, before offering for sale, is a guarantee to the physician that he will certainly obtain the good results he expects from pepsin.

Protonuclein in Vomiting in Pregnancy.—

Case 779. Dr. —— writes: Protonuclein almost worked a miracle; gave one tablet after each meal till patient took twenty-five, and patient never had any more trouble with her stomach during the remaining four months.

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THE NEW ORLEANS POLYCLINIC.—*Thirteenth Annual Session* opens November 20, 1899—closes May 10, 1900. Every inducement in clinical facilities for those attending. The specialties are fully taught. Further information, New Orleans Polyclinic, New Orleans, Louisiana.

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Exchange and Front Streets, Memphis, Tenn.

To the Medical Profession:

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For other work I will charge the following fees: Urinalysis, chemical and microscopical, $2.00; including staining for tubercle bacilli, $3.50. Quantitative for sugar, $2.50. This covers the work necessary to make a conscientious diagnosis, and for *life insurance.* Pus for gonococci and other microörganisms, $2.00. Feces for parasites, eggs, etc., $5.00. Blood for typhoid and yellow fever reaction, for malaria organisms, diphtheria exudate and sputum for tubercle bacilli, $2.00. Other examinations for poisons, etc., according to labor and material consumed.

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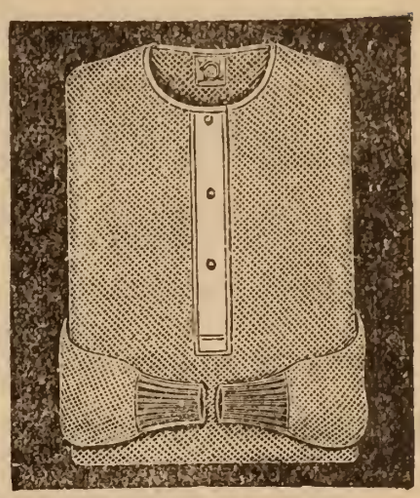

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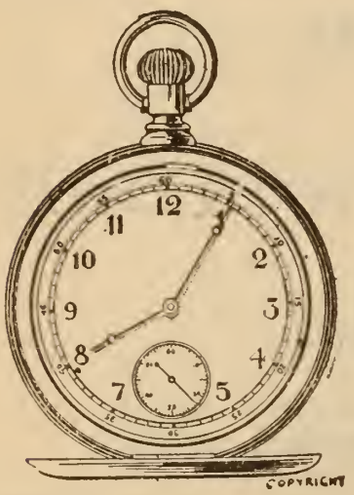

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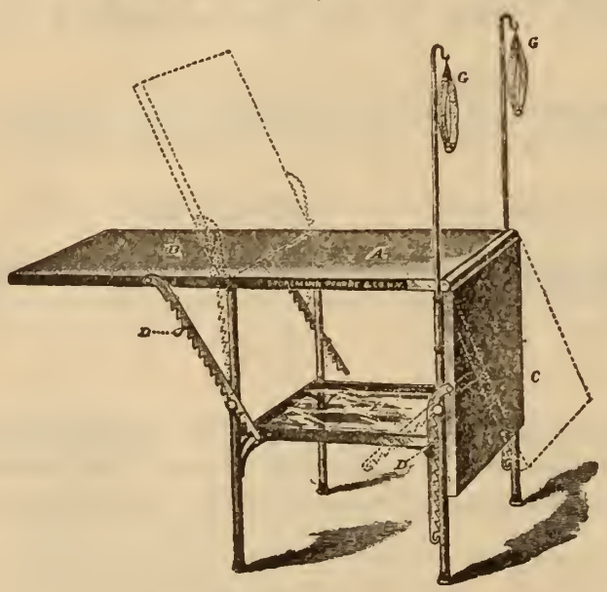

(Taft's Table.)